

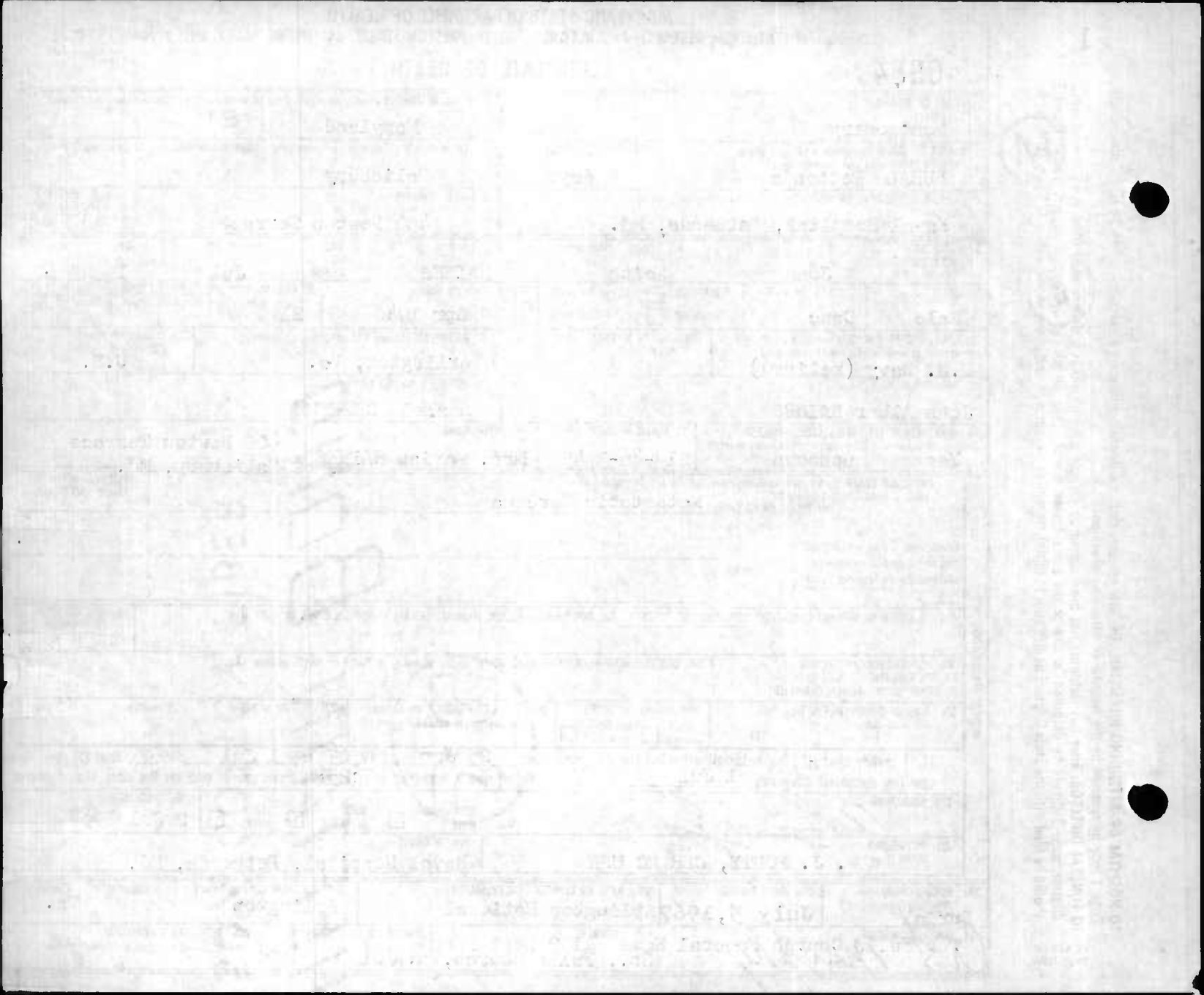
09847

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>400 Newton Terrace</b>	
3. NAME OF DECEASED (Type or print) <b>John Keith RAINES</b>		4. DATE OF DEATH Month <b>Jul</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Apr 1946</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>67</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Arlington, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Alber RAINES</b>		14. MOTHER'S MAIDEN NAME <b>Anabell CHEEZUM</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes unknown</b>		16. SOCIAL SECURITY NO. <b>219-46-3945</b>	
17. INFORMANT <b>Mrs. Marian RAINES</b>		Address <b>400 Newton Terrace Salisbury, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1992</b> IMMEDIATE CAUSE (a) <b>Metastatic Sarcoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>25 Jun</b> , 19 <b>67</b> , to <b>1 Jul</b> , 19 <b>67</b> , that (1) (we) last saw the deceased alive on <b>1 Jul</b> , 19 <b>67</b> , and that death occurred at <b>7:25 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>2 Jul 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. J. FOUTY, CDR MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 5, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>
24. FUNERAL DIRECTOR <i>[Signature]</i> <b>St. Paul's Church Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUL 5 1967</b>	
Address <b>1102 West Broad St., Falls Church, Va.</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

09848

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

09853

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>10501 Eastwood Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>MAGGIE M. READ</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.H.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>7/25/80</u>	9. AGE (In years last birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Leonardtown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Cornelius Milburn</u>				14. MOTHER'S MAIDEN NAME <u>Frances Gatto</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles M. Read</u> Address <u>10501 Eastwood Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>15 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , to <u>July 6</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 6</u> , 1967, and that death occurred at <u>1050 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond Bradshaw</u>				22b. DATE SIGNED <u>July 6, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>	
22d. ADDRESS <u>345 University Blvd. W. Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 10, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Forest Glen, Maryland</u>	
24. FUNERAL DIRECTOR <u>E. Glen Carter</u> <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>				25. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

09849

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09854

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>1 hr.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>3326 Lockheed Blvd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>David William Reynolds</b>				4. DATE OF DEATH Month Day Year <b>July 2, 19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/11/41</b>	9. AGE (In years last birthday) yrs. <b>25</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garden Center</b>		11. BIRTHPLACE (State or foreign country) <b>Chishom, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK W. REYNOLDS</b>				14. MOTHER'S MAIDEN NAME <b>HELMi O. Joki</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>225-52-9613</b>		17. INFORMANT <b>Linda Reynolds</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute severe pulmonary congestion and edema</b> <b>823.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe trauma to lungs</b> DUE TO (c) <b>Fractured ribs and severe impact</b>						INTERVAL BETWEEN ONSET AND DEATH <b>76 min.</b> <b>76 min.</b> <b>76 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemoperitoneum due to lacerations of liver and spleen</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>His car went off road on a curve, rolled over &amp; threw him out.</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:14 p.m. July 2, '67</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. 495</b>		20f. (City or town) (County) (State) <b>Silver Spring, Mont., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)		DATE		22. DATE SIGNED <b>7/2/67</b> <b>1919 Seminary Rd.</b> <b>Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. COMFORT CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>FAIRFAX Co. VA.</b>	
24. FUNERAL DIRECTOR <b>ALEXANDRIA, VA J.S. Evans</b>				25. REGISTRY <b>JUL 7 1967</b>		25b. REGISTER'S SIGNATURE <b>[Signature]</b>	

Alexandria

Virginia

Montgomery

Alexandria

1st

Silver Spring

1936 Potomac River

1st Gros Hospital

27

2

July

Raymond

William

David

12

12/11/41

Card

Male

U

Chatham, Mass.

Garben Center

Manager

and

James Raymond

on

road on a curve, not at over, when the car.

Silver Spring, Md.

X 1st 1st

6:14 (July 26)

X 1st 1st  
Silver Spring, Md.

John H. Rogers, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09850

09855

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY in 1b <b>16 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b> d. STREET ADDRESS <b>11901 Georgia Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ovid</b> First <b>Eli</b> Middle <b>Roberts, Jr.</b> Last		4. DATE OF DEATH <b>July</b> Month <b>12</b> Day <b>1967</b> Year					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/5/91</b>	9. AGE (In years last birthday) <b>76</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General (Rec. Sec.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Rochelle, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ovid Eli Roberts Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Lena Doyle</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I &amp; II</b>			16. SOCIAL SECURITY NO. <b>578-12-2998</b>
17. INFORMANT <b>Mrs. Virginia R. Koier, daughter</b>		Address <b>1121 Chickasaw Dr. Silver Spring, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>260X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery thrombosis</b> (c) <b>Diabetes mellitus + arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>11</b> <b>(1/1960)</b> <b>(2/1950)</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Parahysis agitans -</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 19</b> , <b>1963</b> , to <b>July 12</b> , <b>1967</b> that (I) (we) last saw the deceased alive on <b>July 12</b> , <b>1967</b> , and that death occurred at <b>4:16 A.M.</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>E. Clarence Rice</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>July 12, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. CLARENCE RICE</b>		22d. ADDRESS <b>1150 Connecticut Ave. N.W. Washington, D.C. 20036</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>July 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR <b>Thomas E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

NEW YORK, N.Y., MAY 1, 1961

CERTIFICATE OF DEATH

No. 1-1000

Deceased

15 minutes

1101 George Avenue

1101 George Avenue

1101

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

1101 George Avenue

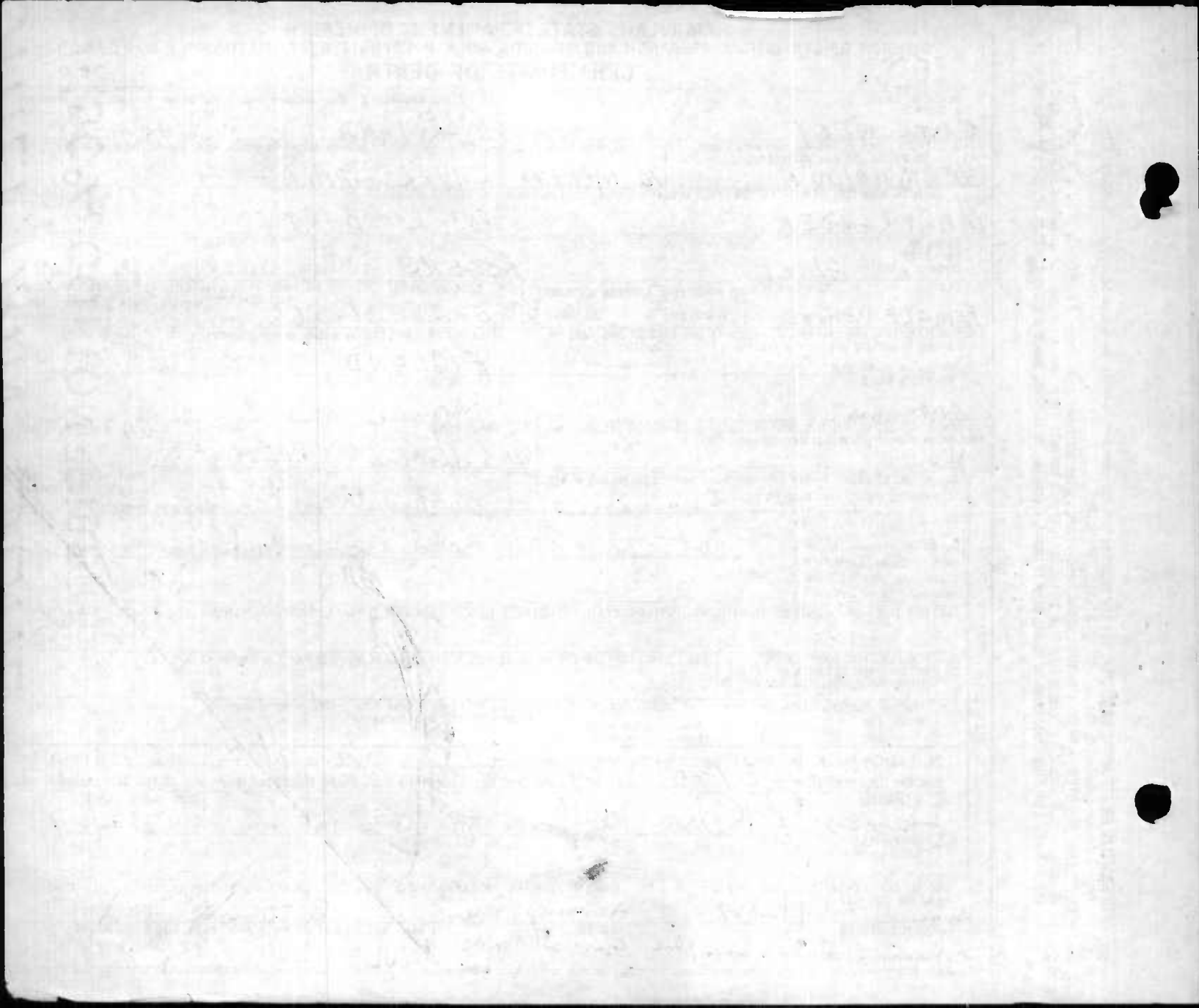
1101 George Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN</u> c. LENGTH OF STAY IN 1b <u>10 MONTHS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MARYLANDER</u>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>MARYLAND</u> <span style="float: right;">b. COUNTY <u>MONTGOMERY</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>803 LOMBARDY CT.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALICE</u>			First <u>ALICE</u>		Middle <u>ROGERS</u>		Last <u>ROGERS</u>		<b>4. DATE OF DEATH</b> Month <u>JULY</u> Day <u>2</u> Year <u>1967</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5-28-01</u>		<b>9. AGE (In years last birthday)</b> <u>66</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>15</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>ENGLAND</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>ABRAHAM</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>RACHAEL</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>M.D. Strajni</u>			Address <u>7 CHESTNUT ST. MD.</u>			
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach with metastases</u> 151X DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 months</u> <u>3 years</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>								
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19 <u>67</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>			<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>		
<b>21. I certify that (I) (this hospital) attended the deceased from <u>4/10</u>, 19<u>66</u> to <u>7/2</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>6/30</u>, 19<u>67</u>, and that death occurred at <u>3 A.M.</u>, from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>James P. Kern, M.D.</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>7/2/67</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b>						<b>22d. ADDRESS</b>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>7/2/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Heaving Run</u>			<b>23d. LOCATION (City, town or county)</b> <b>(State)</b> <u>Baltimore, Md.</u>				
<b>24. FUNERAL DIRECTOR</b> <u>Sydney S. Lewis &amp; Son, Inc.</u>						<b>ADDRESS</b> <u>Germantown, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>DATE JUL 5 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09852

09857

FOR STATE HEALTH DEPT.

M

17

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>1511</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>				d. STREET ADDRESS <u>6613 Eastern Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Norman</u> Last <u>Romm</u>				4. DATE OF DEATH Month <u>7</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-90</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>- - -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sports Wear</u>		11. BIRTHPLACE (State or foreign country) <u>Prussia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>- -</u>		17. INFORMANT Address <u>Wife - Mrs Helen K Romm</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute -</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>- - -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2</u> years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u>		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>7/4/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-7-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Prince Georges Co. Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>JUL 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Dear", "I", "and", "you" are faintly visible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09853

## CERTIFICATE OF DEATH

09858

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. LENGTH OF STAY IN lb <u>2 1/2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Joseph</u> Last <u>Rose</u>		4. DATE OF DEATH Month <u>7</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-3-02</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Joseph Rose</u>		Address <u>3013 Fallston Road Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Essential Hypertension</u> DUE TO (c) <u>Myocardial Infarct</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/29/67</u> to <u>7/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>July 1, 1967</u> , and that death occurred at <u>6:27 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>July 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		22d. ADDRESS <u>10620 Georgia Avenue, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>July 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Glenn Carter</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>

MEDICAL CERTIFICATION

Cleared by Med. Exam. - Dr. Rogers 68 7:15 PM JH ML

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09854

09859

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<u>Holy Cross Hospital - Silver Spring, Md</u>		<u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
<u>1000 Chiswell Lane</u>		<u>15-1</u>	
3. NAME OF DECEASED (Type or print) <u>Leah</u> First Middle Last <u>Rosenbloom</u>		4. DATE OF DEATH <u>July 26</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1892</u> Yrs. <u>75</u>
9. AGE (In years last birthday) <u>75</u> Yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Heshel Plesset</u>		14. MOTHER'S MAIDEN NAME <u>Esther Rabinowitz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joshua Rosenbloom</u> Address <u>Sil.Sp.Md. 1000 Chiswell Ln.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Meenteric Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral thrombosis and coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>Approx. 36 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>6-30</u> , 19 <u>67</u> , to <u>7-26</u> , 19 <u>67</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>7-26</u> , 19 <u>67</u> , and that death occurred at <u>9:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Donald W. Datzow</u> M.D.		22b. DATE SIGNED <u>7-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD W. DATZOW, MD</u>		22d. ADDRESS <u>823 UNIV. BLVD.W, SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Judah Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>New York</u>	
24. FUNERAL DIRECTOR <u>Bernard Danzansky and Sons</u> ADDRESS <u>3501-14th St. NW, Wash. DC</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

W. H. DAVIS, JR.  
1891  
JUL 21 1891

RECEIVED  
JUL 21 1891



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12 1

09855

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09860

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>PR. GEORGETOWN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>55 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edwin Renay ROSS</b>		4. DATE OF DEATH <b>July 4, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1923</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Durant, Oklahoma</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Johnny Clay Ross</b>		14. MOTHER'S MAIDEN NAME <b>Georgia Bartlett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1942-1964 545 26 9353</b>	
17. INFORMANT <b>Springs</b> Address <b>Md.</b>		18. MRS. MARY ROSS, 5921 Farmer Drive, Camp	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the pancreas with erosion into the</b> <b>157X</b> DUE TO <b>G. I. tract and massive hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>May 10</b> , 19 <b>67</b> , to <b>July 4</b> , 19 <b>67</b> , that <del>it</del> (we) last saw the deceased alive on <b>July 4</b> , 19 <b>67</b> , and that death occurred at <b>1035M</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>H. E. Ashworth</b>		22b. DATE SIGNED <b>July 5, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. E. ASHWORTH, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/7/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS <b>4803 Suitland Rd., Suitland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 7 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1955

Washburn

Washburn

Washburn

Washburn

Washburn (Washburn)

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

Washburn

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09856

CERTIFICATE OF DEATH

09861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			c. LENGTH OF STAY IN 1b <b>Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			151
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9732 Glen Ave Apt 202</b>				d. STREET ADDRESS <b>9732 Glen Ave Apt 202</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ANDERSON</b> Last <b>ROSS</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct 3, 1919</b>		9. AGE (In years last birthday) yrs. <b>47</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Expediter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Russell B. Ross</b>				14. MOTHER'S MAIDEN NAME <b>Esta Pearl Gochenaur</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 1943-1944</b>		16. SOCIAL SECURITY NO. <b>579-03-9144</b>		17. INFORMANT <b>7709 Locust Lane, William H. Ross, Oxon Hill, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cervonant thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hour</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/6/66</b> , 19____, to <b>7/17/67</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/1/67</b> , 19____, and that death occurred at <b>11A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Patrick C. Jameson</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Patrick Jameson M. D.</b>				22d. ADDRESS <b>11718 Georgia Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 21, 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Wash, D. C.</b>				25a. REC'D BY REGISTRAR <b>JUL 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

9936

Montgomery

Silver Spring

2732 Glen Ave

White

Exposition

Brasserie H. Ross

Box 1042-1244

Patrick Jameson

United

July 11, 1927

George Lawrence Jones

Montgomery

Silver Spring

2732 Glen Ave

White

Exposition

Brasserie H. Ross

Box 1042-1244

Patrick Jameson

United

July 11, 1927

George Lawrence Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09857

Items #13 & 14 Film #G391 8/1/67 ph

CERTIFICATE OF DEATH

09862

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>12506 Caswell Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>M.</u> Last <u>Rusnock</u>		4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/14</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Peter (Unknown) McHale</u>		14. MOTHER'S MAIDEN NAME <u>Agnes McHale/ Noone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Husband</u> <u>Albert Rusnock</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consistent w/ Lymphoma and Leukemia</u> <u>1992</u> DUE TO <u>involvement of Retroperitoneum,</u> (b) <u>AXILLARY Lymph Nodes</u> DUE TO <u>Mesenteric Lymph. Nodes.</u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>65</u> , to <u>July 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 19</u> , 19 <u>67</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Blaine H. Big</u>		22b. DATE SIGNED <u>7/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. BIG</u>		22d. ADDRESS <u>6641 Colander Rd, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hanover, Penna.</u>
24. FUNERAL DIRECTOR <u>Robert A. Dunphy</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CENTRAL OF DEATH

1992

1

1992 JUL 2 1992



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the remaining pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09863

09858

CERTIFICATE OF DEATH MABEL FRANCES SAMMANS

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>8108 New Hampshire Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Frances</u> Last <u>Sammans</u>		4. DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/22/02</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John T. Hilleary</u>		14. MOTHER'S MAIDEN NAME <u>Florence m hyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Uterus -</u> stating the underlying cause lost. (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 30, 1967</u> , to <u>July 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 7, 1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lysle Williams</u>		22b. DATE SIGNED <u>7/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lysle Williams</u>		22d. ADDRESS <u>831 University Blvd E Silver Spring</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Removal to Anatomy, Dept Georgetown Med. School, D.C. for Research 7/8/67</u>			
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		25c. ADDRESS <u>254 Capitol St NW Washington DC</u>	

1. Name of Soldier: [illegible]  
2. Service Number: [illegible]  
3. Date of Birth: [illegible]  
4. Date of Death: [illegible]  
5. Place of Birth: [illegible]  
6. Place of Death: [illegible]  
7. Cause of Death: [illegible]  
8. Grade: [illegible]  
9. Branch: [illegible]  
10. Regiment: [illegible]  
11. Company: [illegible]  
12. Platoon: [illegible]  
13. Position: [illegible]  
14. Date of Enlistment: [illegible]  
15. Date of Discharge: [illegible]  
16. Date of Promotion: [illegible]  
17. Date of Transfer: [illegible]  
18. Date of Reassignment: [illegible]  
19. Date of Retirement: [illegible]  
20. Date of Death: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09859

CERTIFICATE OF DEATH

09864

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Mong.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>508 Royalton Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAROLINA S. SANDBERG</u>		4. DATE OF DEATH Month <u>7</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/8/80</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>SWEDEN</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Vickston</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-9266</u>	
17. INFORMANT <u>Victor Sandberg</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Lobular Pneumonia</u> DUE TO (b) <u>Cerebral atherosclerosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right frontal lobe cerebral infarction remote</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1967</u> , to <u>July 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>5:25 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw</u>		22b. DATE SIGNED <u>7/6/67</u>	
22c. PHYSICIAN NAME (Type) <u>Raymond Bradshaw, M.D.</u>		22d. ADDRESS <u>345 University Blvd. N. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Glen Carter, 8434 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF ANALYSIS

Sample No. 1000  
Name of Manufacturer  
Address of Manufacturer  
Date of Analysis  
Name of Analyst  
Signature of Analyst

Analysis of Sample No. 1000  
Result of Analysis  
Remarks

Analysis of Sample No. 1000  
Result of Analysis  
Remarks

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

09860

**CERTIFICATE OF DEATH**

09865

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>63 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1336 Missouri Avenue, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gerald Lloyd Sarchet</b>			4. DATE OF DEATH Month Day Year <b>July 20 19 67</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 June 1903</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Project Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>			
13. FATHER'S NAME <b>Lloyd Henry Sarchet</b>			14. MOTHER'S MAIDEN NAME <b>Jennie Fitzsimmons</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1943-45</b>		16. SOCIAL SECURITY NO. <b>548-07-5539</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Malignant Melanoma</b> <b>1909</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>18 May</b> , 19 <b>67</b> , to <b>20 July</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>20 July</b> , 19 <b>67</b> , and that death occurred at <b>11:30M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Bruce Chabner</b>			PM M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>July 21, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Bruce A. Chabner, M. D.</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE THEREOF <b>7/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Ft Geo Co Md.</b>			
24. FUNERAL DIRECTOR <b>Funtlemann &amp; Son</b>			ADDRESS <b>5732 Sh Ave NW</b>		25a. REC'D BY REGISTRAR <b>UL 24 1967</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

STATE OF TEXAS  
COUNTY OF DALLAS  
CITY OF DALLAS  
I, the undersigned, Clerk of the Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Court.

WITNESSED my hand and the seal of the Court at Dallas, Texas, this 1st day of January, 1901.

CLERK OF THE COURT



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09861

CERTIFICATE OF DEATH

09866

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>57 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Virginia</b> Last <b>SCHWARZ</b>		4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 29, 1884</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>47</b> Days <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Alexandria, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thompson Harris</b>		14. MOTHER'S MAIDEN NAME <b>Annie Tatspaugs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578 26 3195</b>	
17. INFORMANT <b>Mr. Thomas H. Harris, 2150 Pennsylvania Ave., N.W.</b>		Address <b>Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis; primary urinary bladder with obstruction of ureters</b> 1810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>obstruction of ureters</b> (c) <b>obstruction of ureters</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 11</b> , 19 <b>67</b> , to <b>July 6</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>July 6</b> , 19 <b>67</b> , and that death occurred at <b>1150 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>F. J. Frensilli</b>		22b. DATE SIGNED <b>July 7, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. J. FRENSILLI, M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 11, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers</b>		25a. REC'D BY REGISTRAR <b>JUL 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		25c. ADDRESS <b>517 11th Street, S. E., Washington, D. C.</b>	

100

Director of Columbia

Montgomery

Washington

July 1957

Montgomery (re:)

1500 Pennsylvania Ave., N.W.

Naval Hospital

July

COINTEL

Virginia

May

Feb. 20, 1954

June

Female

USA

Alamogordo, Virginia

Housewife

Radio Telephone

Thomas Harris

Washington, D.C.

Ave., N.W.

Mr. Thomas H. Harris, 1500 Pennsylvania

operation of mobile  
communication; primary contact with

July 2, 1957

May 12

July 6, 1957

July 1, 1957

Naval Hospital, Bethesda, Md.

T. J. HENSHALL, M. T.

Arlington, Va.

Arlington National

July 11, 1957

217 15th Street, N.E., Washington, D.C.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
 Item #9 Film #G391 7/31/67 ph

09862

**CERTIFICATE OF DEATH**

09867

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Mont.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6815 Eastern ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bernard Kenneth Segal</u> First Middle Last			<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>19</u> Year <u>1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12-1888</u>	9. AGE (In years last birthday) <u>78 7/9</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>			
13. FATHER'S NAME <u>Jacob Segal</u>			14. MOTHER'S MAIDEN NAME <u>Jennie Cohen</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>341-09-6981-A</u>		17. INFORMANT <u>SANFORD SEGAL, SON</u> Address <u>8510-16TH ST SILVER SPRING, MD.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism Arteriosclerotic heart disease</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE <u>Norman H. Rubenstein</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/19/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>			22d. ADDRESS <u>11161 N.H. Ave Silver Spring Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chicago, Illinois.</u>			
24. FUNERAL DIRECTOR <u>Donald M. Stein</u> ADDRESS <u>Hebrew Memorial roll St., N.W. Washington, D. C.</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Dr. Reap.

DEPT. OF STATE

3330

JUL 2 1937

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09863

CERTIFICATE OF DEATH

09868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the certificate to pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Box 92</b>			151
3. NAME OF DECEASED (Type or print) First <b>Arnold</b> Middle <b>Weldon</b> Last <b>Selby</b>		4. DATE OF DEATH Month <b>July</b> Day <b>9</b> Year <b>1967</b>		9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/09</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Cty., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Louis Webster</b>				14. MOTHER'S MAIDEN NAME <b>Annie Bowen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b></b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Olney, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592X ACIDOSIS + UREMIA TERMINAL</b> DUE TO (b) <b>HYPERTENSIVE VASCULAR DISEASE.</b> DUE TO (c) <b>CHRONIC GLOMERULONEPHRITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>YES.</b> <b>YES</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>CIRRHOSIS LIVER, SICKLE CELL ANEMIA, UREMIC GI BLEEDING</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>66</b> to <b>7-9</b> , 19 <b>67</b> , that (2) (we) last saw the deceased alive on <b>7-8</b> , 19 <b>67</b> , and that death occurred at <b>3:35am</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Donald F. Lewis</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-10-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/13/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MT. ZION, MONTG., MD.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b> ADDRESS <b>ROCKVILLE, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>JUL 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

CERTIFICATE OF DEATH

60

1. Name of deceased: JOHN J. BROWN  
2. Date of death: 10-15-1967  
3. Place of death: 1234 Main St., Baltimore, Md.  
4. Cause of death: Myocardial infarction  
5. Manner of death: Natural  
6. Age at death: 68  
7. Sex: Male  
8. Race: White  
9. Marital status: Married  
10. Occupation: Engineer  
11. Education: High School Graduate  
12. Date of birth: 10-15-1899  
13. Place of birth: Baltimore, Md.  
14. Date of death: 10-15-1967  
15. Place of death: 1234 Main St., Baltimore, Md.  
16. Cause of death: Myocardial infarction  
17. Manner of death: Natural  
18. Age at death: 68  
19. Sex: Male  
20. Race: White  
21. Marital status: Married  
22. Occupation: Engineer  
23. Education: High School Graduate  
24. Date of birth: 10-15-1899  
25. Place of birth: Baltimore, Md.

26. Name of informant: John J. Brown  
27. Relationship to deceased: Spouse  
28. Date of death: 10-15-1967  
29. Place of death: 1234 Main St., Baltimore, Md.  
30. Cause of death: Myocardial infarction  
31. Manner of death: Natural  
32. Age at death: 68  
33. Sex: Male  
34. Race: White  
35. Marital status: Married  
36. Occupation: Engineer  
37. Education: High School Graduate  
38. Date of birth: 10-15-1899  
39. Place of birth: Baltimore, Md.  
40. Date of death: 10-15-1967  
41. Place of death: 1234 Main St., Baltimore, Md.  
42. Cause of death: Myocardial infarction  
43. Manner of death: Natural  
44. Age at death: 68  
45. Sex: Male  
46. Race: White  
47. Marital status: Married  
48. Occupation: Engineer  
49. Education: High School Graduate  
50. Date of birth: 10-15-1899  
51. Place of birth: Baltimore, Md.



FOR STATE  
HEALTH DEPT

09864

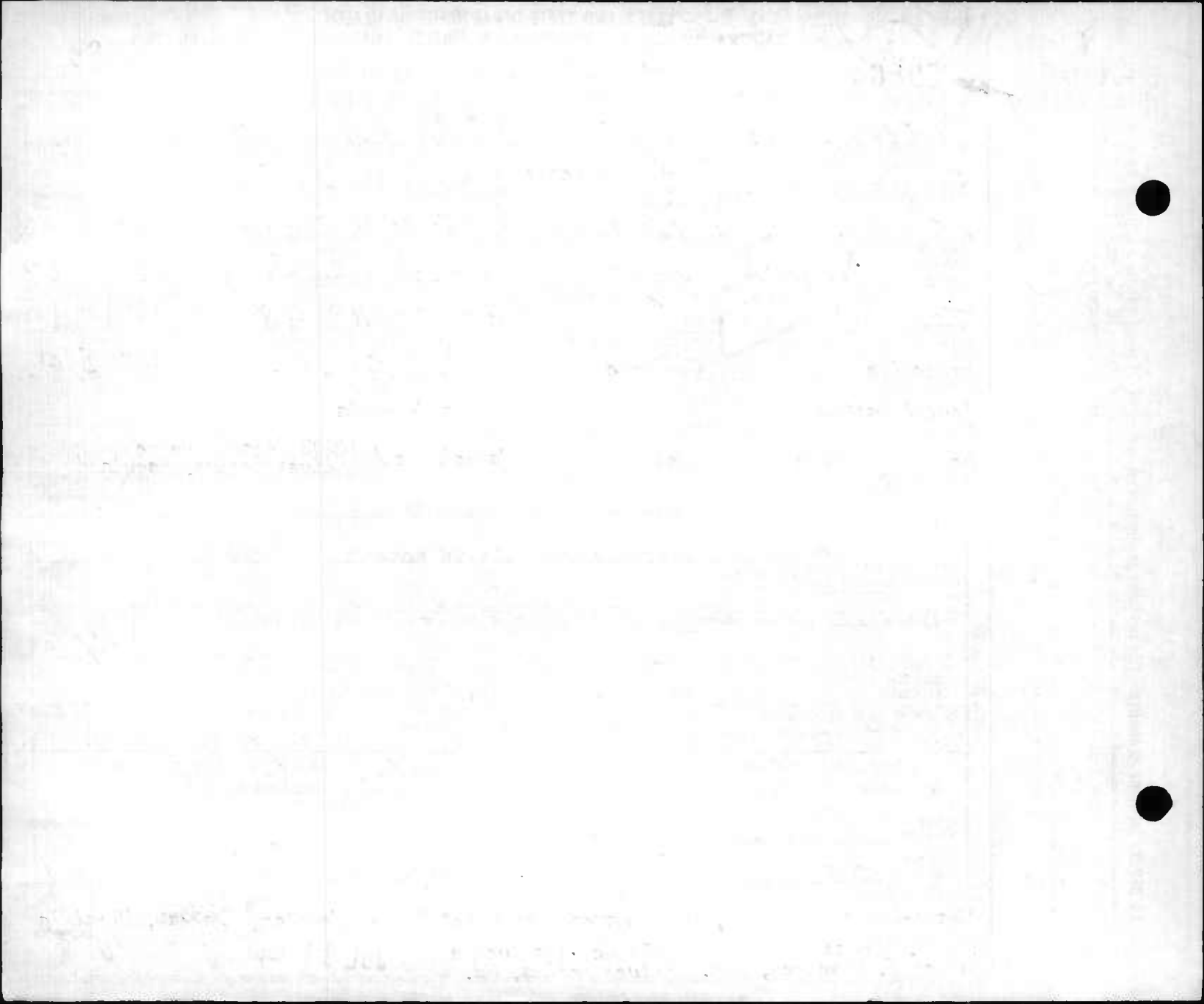
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09869

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 years</u>		d. STREET ADDRESS <u>10202 Lorain Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10202 LORAIN AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY BEATRICE SELF</u>		4. DATE OF DEATH <u>JULY 26 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1919</u>
9. AGE (In years, last birthday) <u>48</u>		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Martin</u>		14. MOTHER'S MAIDEN NAME <u>Ida Columbia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Carroll Self</u>		Address <u>10202 Lorain Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>904.0 Acute subdural hematoma</u>			
DUE TO (b) <u>secondary to fall in home</u>			
DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, drinking, fell at home.</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 p.m. 7/25/ 1967</u>		20d. INJURY OCCURRED <u>2</u> While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>7/26/1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		Address (Street, city, town, or county) <u>4434 Georgia Avenue Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>July 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Church Cemetery</u>	23d. LOCATION (City or town) <u>Wheaton, Virginia</u> (County) <u>  </u> (State) <u>  </u>
24. FUNERAL DIRECTOR <u>John B. Thomas Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JUL 31 1967</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09870

09865

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>Whitmoor</u> <u>132 Whitmoor Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>Edwin</u> Last <u>Shutts</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 August 1911</u>		9. AGE (In years lost birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Audiologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.R.A.H.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Shutts</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>xxx Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>317-20-6389</u>		17. INFORMANT <u>The Medical Record, The Clinical Center, Bethesda, Maryland 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>203X</u> IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO (b) <u>Amyloidosis of Kidney</u> DUE TO (c) <u>Multiple Myeloma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>  <u>1 1/2 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 19</u> , 19 <u>67</u> , to <u>July 13</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 13</u> , 19 <u>67</u> , and that death occurred at <u>11:00M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>V. T. DeVita MD</u>				P.M. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>July 14, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent T. DeVita, Jr. M. D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF TEXAS

1910

1910

1910

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2405 Hannon St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ariel Ellen Simmons</u> First Middle Last						<b>4. DATE OF DEATH</b> Month <u>7</u> Day <u>31</u> Year <u>1967</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/3/1887</u>		<b>9. AGE (in years last birthday)</b> <u>80 yrs.</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Govt. secretary</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Government</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Brantford, Canada</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William McCutcheon</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>220-44-8510</u>		<b>17. INFORMANT</b> <u>Mrs. Lucille Simmons-Hyattsville, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>arteriosclerotic heart disease &amp; generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1-2 days</u> <u>1-2 days</u> <u>years</u>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>C.V.A. (recent) &amp; right hemiplegia &amp; aphasia, dysphagia</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u>, 19<u>66</u>, to <u>July 31</u>, 19<u>67</u>, that (II) (we) last saw the deceased alive on <u>July 30</u>, 19<u>67</u>, and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>John R. Spencer</u>						<b>22b. DATE SIGNED</b> <u>Aug 2 1967</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>John R. Spencer, M.D.</u>		<b>22d. ADDRESS</b> <u>1544 Columbia Rd., Burtonsville, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>burial</u>				<b>23b. DATE THEREOF</b> <u>8/3/67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cem.</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Ft. Myer, Va.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Wm. S. Hines Company</u> <u>2901 14th St. N.W. Washington, D.C.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>AUG 2 1967</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

1975

RECEIVED BY STAFF

DATE: 1975-01-15

TO: Mr. [Name]

FROM: Mr. [Name]

SUBJECT: [Subject]

RE: [Subject]

1. [Text]

2. [Text]

3. [Text]

4. [Text]

5. [Text]

6. [Text]

7. [Text]

8. [Text]

9. [Text]

10. [Text]

11. [Text]

12. [Text]

13. [Text]

14. [Text]

15. [Text]

16. [Text]

17. [Text]

18. [Text]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09867					09872				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			c. LENGTH OF STAY IN 1b <b>2 months</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Potomac</b>			151	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Oakhaven Convalescent Home</b>					d. STREET ADDRESS <b>11021 Brent Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise B. Skipper</b>			First Middle Last		4. DATE OF DEATH <b>July 25 1967</b>		Month Day Year		
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan 29, 1891</b>		9. AGE (In years, last birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James Brown</b>					14. MOTHER'S MAIDEN NAME <b>Louisa Matheny</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mrs. Dorothy Wilson, 11021 Brent Rd. Potomac Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> <b>Brain Bronchitis, Esophageal weakness, transition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Agonal discharge, probably due to recurrent Ca.</b> (c) <b>General arteriosclerosis, cerebral</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Spent in Cd of Colon a few yrs ago</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <b>6/15/67</b> to <b>7/23/67</b> , that (I) (we) last saw the deceased alive on <b>7/23/67</b> , and that death occurred at <b>8:05</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Chas H. Wolohan, MD</b>		22b. DATE SIGNED <b>7-26-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Chas H. Wolohan, MD</b>			22d. ADDRESS <b>831 University Blvd. E. Silver Spring, Md.</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>7-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>					25a. REC'D BY REGISTRAR <b>JUL 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove barbarian papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09868

CERTIFICATE OF DEATH

09873

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		d. STREET ADDRESS <b>124 Grafton Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Catharine</b> Middle <b>Hopkins</b> Last <b>SLACK</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1913</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Annapolis, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walton H. Hopkins</b>		14. MOTHER'S MAIDEN NAME <b>Lila H. Trenholm</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-40-6085</b>	
17. INFORMANT <b>1401 Crystal Pkwy</b> Address <b>Virginia Beach</b> <b>Capt. Thomas W. Hopkins, USN, Ret. /</b> Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer breast with widespread metastases</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>June 27</b> , 19 <b>67</b> , to <b>July 31</b> , 19 <b>67</b> , that <del>(X)</del> (we) last saw the deceased alive on <b>July 31</b> , 19 <b>67</b> , and that death occurred at <b>510A M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Francis D. Keenan, Jr.</b> M.D.		22b. DATE SIGNED <b>July 31, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis D. Keenan, Jr.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Owensville, Maryland</b>
24. FUNERAL DIRECTOR <b>John M. Taylor Funeral Home</b> <b>147-149 Gloucester St., Annapolis, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



09869

09874

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>12 1/2 Hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20014 <b>The Clinical Center, Bethesda, Maryland</b>		e. STREET ADDRESS <b>Dungannon</b> <b>Box 365</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Morris</b> Last <b>Sluss</b>		4. DATE OF DEATH Month <b>July</b> Day <b>12</b> Year <b>19 67</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 October 1924</b>	
9. AGE (In years last birthday) <b>42 yrs.</b>		10. UNDER 1 YEAR Months <b>42</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>	
13. FATHER'S NAME <b>William M. Sluss</b>		14. MOTHER'S MAIDEN NAME <b>Mary Lowe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-18-3425</b>	
17. INFORMANT <b>The Medical Record, The Clinical Center, Bethesda, Maryland 20014</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>artery</b> (b) <b>Occlusion left anterior descending coronary</b> DUE TO <b>1 week</b> (c) <b>Coronary artery disease</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatic heart disease - mitral insufficiency</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>July 12</b> , 19 <b>67</b> , to <b>July 12</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>July 12</b> , 19 <b>67</b> , and that death occurred at <b>11:14 P.M.</b> causes and on the date stated above			
22a. SIGNATURE <b>Lawrence Saul Cohen</b>		22b. DATE SIGNED <b>14 July 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Saul Cohen, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>7-15-67</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State) <b>Coburn, Va</b>	
24. FUNERAL DIRECTOR <b>Travis 389 B.I. on W. Wash. D.C.</b>		25a. REC'D BY REGISTRAR <b>JUL 24 1967</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capcan papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, ~~within~~ within 72 hours after death.

VR A15 (4)  
25M 1/67

MINUTE TO SIGN

James J. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09870

09875

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>3-months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				d. STREET ADDRESS <u>13423 Parkland Dr</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Waple-Smith</u>				4. DATE OF DEATH Month <u>7</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-9-1881</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>David Steele</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Washburn</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Mrs. Elma Smith same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4RS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/1</u> , 19 <u>66</u> to <u>7/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/19</u> , 19 <u>67</u> , and that death occurred at <u>4:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/19/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. BENACK MD</u>				22d. ADDRESS <u>4115 Colie Dr. Wheaton MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>Simmons Bros. 1661-Gd. Hope Rd. SE. Wash., DC</u>				25a. REC'D BY REGISTRAR <u>JUL 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

3 months  
2 months  
1 month  
10 days  
5 days  
2 days  
1 day  
86

Residence  
Cause of death  
Age  
Sex  
Color  
Marital status  
Occupation  
Education  
Religion  
Ethnicity  
Date of birth  
Date of death  
Place of birth  
Place of death  
Signature of physician  
Signature of registrar  
Signature of witness

1901  
1902  
1903  
1904  
1905  
1906  
1907  
1908  
1909  
1910  
1911  
1912  
1913  
1914  
1915  
1916  
1917  
1918  
1919  
1920  
1921  
1922  
1923  
1924  
1925  
1926  
1927  
1928  
1929  
1930  
1931  
1932  
1933  
1934  
1935  
1936  
1937  
1938  
1939  
1940  
1941  
1942  
1943  
1944  
1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025  
2026  
2027  
2028  
2029  
2030  
2031  
2032  
2033  
2034  
2035  
2036  
2037  
2038  
2039  
2040  
2041  
2042  
2043  
2044  
2045  
2046  
2047  
2048  
2049  
2050  
2051  
2052  
2053  
2054  
2055  
2056  
2057  
2058  
2059  
2060  
2061  
2062  
2063  
2064  
2065  
2066  
2067  
2068  
2069  
2070  
2071  
2072  
2073  
2074  
2075  
2076  
2077  
2078  
2079  
2080  
2081  
2082  
2083  
2084  
2085  
2086  
2087  
2088  
2089  
2090  
2091  
2092  
2093  
2094  
2095  
2096  
2097  
2098  
2099  
2100

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09871

CERTIFICATE OF DEATH

09876

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>75-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>71 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewistown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>				d. STREET ADDRESS <u>33 East Chestnut Street,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Joanna</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 24, 1903</u>		9. AGE (In years lost birthday) yrs. <u>63</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vicose Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Smith</u>				14. MOTHER'S MAIDEN NAME <u>Carie McGirk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>188-07-2327</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Md. 20014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypotension and shock</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Septicemia and pneumonia</u> DUE TO (c) <u>Acute myelocytic leukemia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>24 hours</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 24</u> , 19 <u>67</u> , to <u>July 4</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 4</u> , 19 <u>67</u> , and that death occurred at <u>7:27</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>E. J. Hocutt</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edgar J. Hocutt, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Luthern</u>		23d. LOCATION (City or Town) (County) (State) <u>Lewistown, Mifflin Co., Pa.</u>		
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Le Directeur General des Statistiques  
Monsieur le Ministre  
Monsieur le Gouverneur  
Monsieur le Prefet  
Monsieur le Procureur General  
Monsieur le Juge d'Instruction  
Monsieur le Juge de Paix  
Monsieur le Maire  
Monsieur le Chef de Poste  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division

Le Directeur General des Statistiques  
Monsieur le Ministre  
Monsieur le Gouverneur  
Monsieur le Prefet  
Monsieur le Procureur General  
Monsieur le Juge d'Instruction  
Monsieur le Juge de Paix  
Monsieur le Maire  
Monsieur le Chef de Poste  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division

Le Directeur General des Statistiques  
Monsieur le Ministre  
Monsieur le Gouverneur  
Monsieur le Prefet  
Monsieur le Procureur General  
Monsieur le Juge d'Instruction  
Monsieur le Juge de Paix  
Monsieur le Maire  
Monsieur le Chef de Poste  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division

Le Directeur General des Statistiques  
Monsieur le Ministre  
Monsieur le Gouverneur  
Monsieur le Prefet  
Monsieur le Procureur General  
Monsieur le Juge d'Instruction  
Monsieur le Juge de Paix  
Monsieur le Maire  
Monsieur le Chef de Poste  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division

Le Directeur General des Statistiques  
Monsieur le Ministre  
Monsieur le Gouverneur  
Monsieur le Prefet  
Monsieur le Procureur General  
Monsieur le Juge d'Instruction  
Monsieur le Juge de Paix  
Monsieur le Maire  
Monsieur le Chef de Poste  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division  
Monsieur le Chef de Bureau  
Monsieur le Chef de Service  
Monsieur le Chef de Section  
Monsieur le Chef de Division  
Monsieur le Chef de Sous-Division

COLLEGE D'ALGERIE  
BIBLIOTHEQUE  
ALGERIE

7 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

7 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Items 18 & 21, Film G 391 8/18/67 eac

09877

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 473			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>				d. STREET ADDRESS <u>4315 VAN NESS ST. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>HAROLD CLINTON SMITH</u>				4. DATE OF DEATH <u>JULY 26 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-82</u>	
9. AGE (In years less birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Const. Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>VERMONT</u>	
13. FATHER'S NAME <u>Clinton Smith</u>				14. MOTHER'S MAIDEN NAME <u>Alice White</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>				16. SOCIAL SECURITY NO. <u>577-40-7328</u>		17. INFORMANT <u>HOSP. RECORDS</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Keap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (City or town, County)			
22. DATE SIGNED <u>7/26/1967</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-29-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR <u>JUL 31 1967</u> DATE			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "X" and "100" are visible.]*

1000 West 1st St. N. W. Wash. D. C. 20004  
Phone: 2-2222  
JUL 31 1957



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

09873

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09878

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>3342 Lockheed Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Sean</b> Middle <b>Derek</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>21 July 1967</b>
9. AGE (In years last birthday) yrs. <b>8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>0</b>	
IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>✓</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>✓</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Fort Belvoir, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Howard A. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Ona Jean Moore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Howard A. Smith</b>		Address <b>3342 Lockheed Blvd (apt 202) Alexandria, Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>27 July</b> , 19 <b>67</b> , to <b>29 July</b> , 19 <b>67</b> , that <b>(X)</b> (we) lost the deceased alive on <b>29 July</b> , 19 <b>67</b> , and that death occurred on <b>6:00P.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>T. E. Kelly</b>		22b. DATE SIGNED <b>30 July 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>T. E. KELLY, LT MC USN</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>30 July 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Midwest Garden of Memories Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waterloo, Iowa</b>	
24. FUNERAL DIRECTOR <b>Rinaldi Funeral Home, 7400 Georgia Ave., N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

© 2006 The Authors  
Journal compilation © 2006 Blackwell Publishing Ltd

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)  
5M 1/65

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09874		09880	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Evvington</u>	
c. LENGTH OF STAY IN 1b <u>5 mo.</u>		d. STREET ADDRESS <u>Mount Pleasant</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Estelle E. Steenson</u>		4. DATE OF DEATH <u>July 2 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14 1896</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Et. Lee, N. Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gustave Holmberg</u>		14. MOTHER'S MATEOEN NAME <u>Amanda Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>093-24-1761-A</u>	
17. INFORMANT <u>Beatrice B. Harbin</u>		Address <u>12103 Conn. Ave. Wheaton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Cervix</u> DUE TO (c) <u>5 3/4 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 3/4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John D. Rogers M.D.</u>		22. DATE SIGNED <u>July 2, 1967</u>	
EXAMINER'S NAME (Type) <u>John D. Rogers M.D.</u>		Address (Street, city, town, or county) <u>12103 Conn. Ave. Wheaton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur. - Transit</u>		23b. DATE THEREOF <u>7/5/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ferncliff</u>		23d. LOCATION (City, town or county) (State) <u>Dobbs Ferry, New York</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 6 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

TO THE HONORABLE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.

FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY

SUBJECT: [Illegible]

Enclosed for the Bureau of Plant Industry are two copies of a report on the results of the investigation conducted by the Bureau of Plant Industry during the year 1911.

Very respectfully,  
[Illegible Signature]

Very respectfully,  
[Illegible Signature]

Enclosed for the Bureau of Plant Industry are two copies of a report on the results of the investigation conducted by the Bureau of Plant Industry during the year 1911.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09875

CERTIFICATE OF DEATH

09881

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rendolph Hills Nursing Home</u>		d. STREET ADDRESS <u>4429 Harrison St.</u>	
3. NAME OF DECEASED (Type or print) <u>George Everett Stevens</u>		4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-1897</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Industry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George T. Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Emma Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. Navy</u>		16. SOCIAL SECURITY NO. <u>517-07-5343-A</u>	
17. INFORMANT <u>John W. Stevens (same as #2)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain tumor, left temporal lobe</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> , 19 <u>67</u> , to <u>July 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 20</u> , 19 <u>67</u> , and that death occurred at <u>9:25 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Elaine W. Murphy</u>		22b. DATE SIGNED <u>July 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elaine W. Murphy,</u>		22d. ADDRESS <u>4812 Ellicott St NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>AUG. 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, Va.</u>	
24. FUNERAL DIRECTOR <u>DeVol Funeral Home, Wisconsin Ave.</u>		25a. REC'D BY REGISTRAR <u>DAUG 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>			

[illegible]

PG-7

07. 11.81-91 - 6 2 00 21. 3 22. 10

2.0 0.0 1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0 20.0 21.0 22.0 23.0 24.0 25.0 26.0 27.0 28.0 29.0 30.0 31.0 32.0 33.0 34.0 35.0 36.0 37.0 38.0 39.0 40.0 41.0 42.0 43.0 44.0 45.0 46.0 47.0 48.0 49.0 50.0 51.0 52.0 53.0 54.0 55.0 56.0 57.0 58.0 59.0 60.0 61.0 62.0 63.0 64.0 65.0 66.0 67.0 68.0 69.0 70.0 71.0 72.0 73.0 74.0 75.0 76.0 77.0 78.0 79.0 80.0 81.0 82.0 83.0 84.0 85.0 86.0 87.0 88.0 89.0 90.0 91.0 92.0 93.0 94.0 95.0 96.0 97.0 98.0 99.0 100.0

(9-452-7012) II + III + IV + V

Devil - John W. DeWitt



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09876

09882

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DETHESDA</u>		c. LENGTH OF STAY IN 1b <u>70</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>4225 Roundhill Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE MARIE STEWART</u>		4. DATE OF DEATH Month Day Year <u>JULY 25 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 6 - 1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles H. Burke</u>		14. MOTHER'S MAIDEN NAME <u>Mary William Boorman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-58-943</u>	
17. INFORMANT <u>Old same.</u>		Address <u>Mr. Joseph R. Stewart (Husband)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c) <u>2 hrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>1962</u> to <u>25 July</u> , 19 <u>67</u> , that (a) (we) last saw the deceased alive on <u>25 July</u> , 19 <u>67</u> , and that death occurred at <u>1253</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Delwitt E. DeLawter</u>		22b. DATE SIGNED <u>July 25, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLawter MD.</u>		22d. ADDRESS <u>8025 ABERDEEN RD Bethesda Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 28, 1967</u>	23c. NAME OF CEMETERY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Charles H. Davis

255-10-12 1/2 of 100,000,000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

09877

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09883

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>16 1/2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San. &amp; Hospital</i>		d. STREET ADDRESS <i>812 Davis Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Miss Ethel H. Storck</i>		4. DATE OF DEATH Month <i>7</i> Day <i>13</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 16-1899</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Secretary</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>George W. Storck</i>		14. MOTHER'S MARDEN NAME <i>Mary Frances</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>090-09-6316</i>	
17. INFORMANT <i>Donald Storck</i>		Address <i>12 Brooklands Brynsville N.Y.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4200</i> <i>Acute congestive heart failure due to</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Fatty liver</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fatty liver</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/17/1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>		23d. LOCATION (City or town) (County) (State) <i>Falls Church Virginia</i>	
24. FUNERAL DIRECTOR <i>Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>JUL 17 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>		25c. DATE <i>JUL 17 1967</i>	

Received of the  
Honble the Secy to the  
Treasury the sum of  
\$1000000  
for the purchase of  
the Louisiana Territory  
the 20th day of April  
1803

(1)

Witness my hand and  
the seal of the said  
Treasury the 20th day  
of April 1803

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

I

Cleared with medical examiner

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
09878											
09884											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Stephenson</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>						c. LENGTH OF STAY IN 1b <u>10 months</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13102 Grenoble Drive</u>						e. STREET ADDRESS <u>725 West Evan Street</u>					
3. NAME OF DECEASED (Type or print) <u>Clara Howe Stover</u>						4. DATE OF DEATH <u>July 25 1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1883</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Freeport, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachary Taylor Howe</u>						14. MOTHER'S MAIDEN NAME <u>Mary E. Rebolt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give number and date of service)						16. SOCIAL SECURITY NO. <u>323-20-9039</u>		17. INFORMANT <u>Donald H. Stover</u> <u>13102 Grenoble Drive Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1958, 1959</u> to <u>July 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1967</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 25, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>						22d. ADDRESS <u>345 University Blvd, W. Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>July 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Freeport, Illinois</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>						ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>JUL 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967

1967



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09879

CERTIFICATE OF DEATH

09885

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLCOTT CITY</b> 13-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>10 DEWEY DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KNUT</b> Middle <b>ERNFRID</b> Last <b>STROMBERG</b>				4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1882</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOILER MAKER (RETIRED)</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>SWEDEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ALEXANDER STROMBERG</b>				14. MOTHER'S MAIDEN NAME <b>MATHILDA BLOOMBERG</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEDICAL RECORD DEPT.</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA - DURATION ONE WEEK</b> 4/46X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NEPHROSCLEROSIS - SIX MONTHS</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>6 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-8</b> , 19 <b>67</b> , to <b>7-16</b> , 19 <b>67</b> , and that death occurred at <b>6A.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>C. S. Whitaker</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>				22d. ADDRESS <b>CLARKSVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 22, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LaGrange Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Titusville, Florida</b>	
24. FUNERAL DIRECTOR <b>Harry H. Witzke, 321 Columbia Pike, Ellicott City, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 20 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove varying papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09880

## CERTIFICATE OF DEATH

09886

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. LENGTH OF STAY IN 1b <b>lengthly</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairland Nursing Home</b>		e. STREET ADDRESS <b>254 Dill Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>E. M.</b> Last <b>STULL</b>		4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1877</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		12. 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13. FATHER'S NAME <b>Nathan Milbourne</b>		14. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-1835T</b>	
17. INFORMANT <b>Miss Dorothy B. Milbourne</b>		18. ADDRESS <b>801 Venice Drive Silver Spring, Md.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b> <b>4RS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/19</b> , 19 <b>66</b> , to <b>7/19</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>7/13</b> , 19 <b>67</b> , and that death occurred at <b>2 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>R.T. Benack</b>		22b. DATE SIGNED <b>7/15/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.T. Benack MD</b>		22d. ADDRESS <b>4115 Colie Drive Wheaton MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-17-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Bailey &amp; Son</b>		25a. REC'D BY REGISTRAR <b>JUL 20 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>[Signature]</b>	

Form with multiple sections and fields, including a header area with a date field (1968) and a title field (MEMORANDUM FOR THE DIRECTOR). The form contains several paragraphs of text, some of which are partially obscured by the scanning process. The text appears to be a memorandum or report, discussing various matters related to the organization. The form is divided into sections by horizontal lines, and some fields are labeled with numbers or letters. The overall layout is typical of a standard memorandum form from the late 1960s.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09881

09887

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>11818 Charen Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Henry K. Taira</u>		4. DATE OF DEATH <u>7-8</u> 19 <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>ORIENTAL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/10/01</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relief - Owner-Gen. Store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Japan</u>	
11. BIRTHPLACE (State or foreign country) <u>Japan</u>		12. CITIZEN OF WHAT COUNTRY? <u>Japan</u>	
13. FATHER'S NAME <u>Kazusuke Taira</u>		14. MOTHER'S MAIDEN NAME <u>Ushi Taira mine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>710</u>	
17. INFORMANT <u>K. Shimaburo</u>		Address <u>Son-in-law - Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute.</u> DUE TO (b) <u>Cardiovascular Disease.</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md</u>	
24. FUNERAL DIRECTOR <u>The S. H. Hines Company</u>		25. REC'D BY REGISTRAR <u>JUL 11 1967</u>	
ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (or don't papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

098882

098888

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>2 yrs 27 da</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>UNKNOWN</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>C</u> Last <u>Tauber</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1878</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u>8</u> Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TURKEY</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Louis Finkelstein</u>		14. MOTHER'S MAIDEN NAME <u>ROSE (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-54-8972</u>	
17. INFORMANT <u>GABRIEL TAUBER</u> Address <u>4201 CATHEDRAL AVENUE NW WASH., D.C. 20016</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG.</u> , 19 <u>64</u> to <u>JULY 11</u> , 19 <u>67</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>JULY 11</u> , 19 <u>67</u> , and that death occurred at <u>8:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <u>7-11-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-13-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>FALLS CHURCH, VIRGINIA</u>	
24. FUNERAL DIRECTOR <u>Jos. Hawley &amp; Sons Inc. Wash. DC</u>		25a. REC'D BY REGISTRAR <u>JUL 20 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09883

CERTIFICATE OF DEATH

09889

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Both</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hot Springs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>Malvern Mall</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>W.</u> Last <u>TELLIER</u>		4. DATE OF DEATH <u>July 29, 1967</u> Month <u>July</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-95</u> 9. AGE (In years last birthday) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>
13. FATHER'S NAME <u>William Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Laura Ann Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>226-62-6098</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, general, cerebral, coronary</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>2 strokes one on L and last one on midbrain</u> DUE TO (c) <u>Myocardial infarction several yrs ago</u>		19. INTERVAL BETWEEN ONSET AND DEATH <u>9 yrs ago</u> <u>3 1/2 months ago</u> <u>8-10</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> , 19 <u>67</u> , to <u>7/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 29</u> , 19 <u>67</u> , and that death occurred at <u>4:50</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Chas H Wolohun, M.D.</u>		22b. DATE SIGNED <u>July 25th 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohun</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>7/30/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tyronza</u>	23d. LOCATION (City or Town) (County) (State) <u>W. Memphis, Arkansas</u>
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons</u>		25a. REC'D BY REGISTRAR <u>5130 W. Ave. NW</u> DATE <u>AUG 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

20883

July 20, 1962

Medical History

Age: 70

Yes

Signature of Physician

AC

7/20/1962

Physician

Signature

John G. Galt, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G391 8/1/67

CERTIFICATE OF DEATH

09884

09890

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Richwood</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>109 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>18 Ellen Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Ralph</b> Middle <b>Eugene</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>18 March 1936</b>	9. AGE (In years last birthday) <b>30 3 yrs.</b>	10. IF UNDER 1 YEAR Months <b>30</b> Days <b>3</b> Hours <b>3</b> Min.		11. IF UNDER 24 HRS. Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Hugh Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Pearl Baldwin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1955-1959</b>			16. SOCIAL SECURITY NO. <b>299-30-5686</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory collapse</b> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diffuse pneumonia with multiple organisms</b> DUE TO (c) <b>Chronic myelogenous leukemia with marrow fibrosis</b> 5 years						INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b> <b>2 months</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from <b>6 April</b> , 19 <b>67</b> , to <b>24 July</b> , 19 <b>67</b> , that (A) (we) last saw the deceased alive on <b>24 July</b> , 19 <b>67</b> , and that death occurred at <b>4:55AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Bruce A. Chabner</b>				22b. DATE SIGNED <b>24 July 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>Bruce A. Chabner</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, RURAL (Type)		23b. DATE THEREOF <b>7-28-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt View Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Richwood West Virginia</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>JUL 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

OFFICE OF DEATH

STATE OF NEW YORK  
IN SENATE  
JANUARY 10, 1910

REPORT OF THE  
COMMISSIONER OF DEATH

FOR THE YEAR 1909

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910

ALBANY: J.B. LIPPINCOTT & CO., PRINTERS

1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09885

09891

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>				e. STREET ADDRESS <u>204 Glendola Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Sheila</u> Middle <u>Ann</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>15 October 1944</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Julius H. Kitchin</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Ray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT <u>The Medical Record</u> address <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> <u>7540</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure, cardiac arrest</u> DUE TO (c) <u>Tetralogy of Fallot</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>  <u>22 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 June</u> , 1967, to <u>4 July</u> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>4 July</u> , 1967, and that death occurred at <u>1005M</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Lynn M. Peterson</u>				22b. DATE SIGNED <u>5 July 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Lynn M. Peterson, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHAMPION CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>CHAMPION TOWNSHIP, OHIO</u>	
24. FUNERAL DIRECTOR <u>JCS. GAWLER'S SONS, 5130 W. S. AVE., WASH., D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

STATEMENT OF WORK

Project Name		Project Number		Project Status	
Project A		1001		Completed	
Project B		1002		In Progress	
Project C		1003		On Hold	
Project D		1004		Planned	
Project E		1005		Completed	
Project F		1006		In Progress	
Project G		1007		On Hold	
Project H		1008		Planned	
Project I		1009		Completed	
Project J		1010		In Progress	
Project K		1011		On Hold	
Project L		1012		Planned	
Project M		1013		Completed	
Project N		1014		In Progress	
Project O		1015		On Hold	
Project P		1016		Planned	
Project Q		1017		Completed	
Project R		1018		In Progress	
Project S		1019		On Hold	
Project T		1020		Planned	
Project U		1021		Completed	
Project V		1022		In Progress	
Project W		1023		On Hold	
Project X		1024		Planned	
Project Y		1025		Completed	
Project Z		1026		In Progress	
Project AA		1027		On Hold	
Project AB		1028		Planned	
Project AC		1029		Completed	
Project AD		1030		In Progress	
Project AE		1031		On Hold	
Project AF		1032		Planned	
Project AG		1033		Completed	
Project AH		1034		In Progress	
Project AI		1035		On Hold	
Project AJ		1036		Planned	
Project AK		1037		Completed	
Project AL		1038		In Progress	
Project AM		1039		On Hold	
Project AN		1040		Planned	
Project AO		1041		Completed	
Project AP		1042		In Progress	
Project AQ		1043		On Hold	
Project AR		1044		Planned	
Project AS		1045		Completed	
Project AT		1046		In Progress	
Project AU		1047		On Hold	
Project AV		1048		Planned	
Project AW		1049		Completed	
Project AX		1050		In Progress	
Project AY		1051		On Hold	
Project AZ		1052		Planned	
Project BA		1053		Completed	
Project BB		1054		In Progress	
Project BC		1055		On Hold	
Project BD		1056		Planned	
Project BE		1057		Completed	
Project BF		1058		In Progress	
Project BG		1059		On Hold	
Project BH		1060		Planned	
Project BI		1061		Completed	
Project BJ		1062		In Progress	
Project BK		1063		On Hold	
Project BL		1064		Planned	
Project BM		1065		Completed	
Project BN		1066		In Progress	
Project BO		1067		On Hold	
Project BP		1068		Planned	
Project BQ		1069		Completed	
Project BR		1070		In Progress	
Project BS		1071		On Hold	
Project BT		1072		Planned	
Project BU		1073		Completed	
Project BV		1074		In Progress	
Project BW		1075		On Hold	
Project BX		1076		Planned	
Project BY		1077		Completed	
Project BZ		1078		In Progress	
Project CA		1079		On Hold	
Project CB		1080		Planned	
Project CC		1081		Completed	
Project CD		1082		In Progress	
Project CE		1083		On Hold	
Project CF		1084		Planned	
Project CG		1085		Completed	
Project CH		1086		In Progress	
Project CI		1087		On Hold	
Project CJ		1088		Planned	
Project CK		1089		Completed	
Project CL		1090		In Progress	
Project CM		1091		On Hold	
Project CN		1092		Planned	
Project CO		1093		Completed	
Project CP		1094		In Progress	
Project CQ		1095		On Hold	
Project CR		1096		Planned	
Project CS		1097		Completed	
Project CT		1098		In Progress	
Project CU		1099		On Hold	
Project CV		1100		Planned	
Project CW		1101		Completed	
Project CX		1102		In Progress	
Project CY		1103		On Hold	
Project CZ		1104		Planned	
Project DA		1105		Completed	
Project DB		1106		In Progress	
Project DC		1107		On Hold	
Project DD		1108		Planned	
Project DE		1109		Completed	
Project DF		1110		In Progress	
Project DG		1111		On Hold	
Project DH		1112		Planned	
Project DI		1113		Completed	
Project DJ		1114		In Progress	
Project DK		1115		On Hold	
Project DL		1116		Planned	
Project DM		1117		Completed	
Project DN		1118		In Progress	
Project DO		1119		On Hold	
Project DP		1120		Planned	
Project DQ		1121		Completed	
Project DR		1122		In Progress	
Project DS		1123		On Hold	
Project DT		1124		Planned	
Project DU		1125		Completed	
Project DV		1126		In Progress	
Project DW		1127		On Hold	
Project DX		1128		Planned	
Project DY		1129		Completed	
Project DZ		1130		In Progress	
Project EA		1131		On Hold	
Project EB		1132		Planned	
Project EC		1133		Completed	
Project ED		1134		In Progress	
Project EE		1135		On Hold	
Project EF		1136		Planned	
Project EG		1137		Completed	
Project EH		1138		In Progress	
Project EI		1139		On Hold	
Project EJ		1140		Planned	
Project EK		1141		Completed	
Project EL		1142		In Progress	
Project EM		1143		On Hold	
Project EN		1144		Planned	
Project EO		1145		Completed	
Project EP		1146		In Progress	
Project EQ		1147		On Hold	
Project ER		1148		Planned	
Project ES		1149		Completed	
Project ET		1150		In Progress	
Project EU		1151		On Hold	
Project EV		1152		Planned	
Project EW		1153		Completed	
Project EX		1154		In Progress	
Project EY		1155		On Hold	
Project EZ		1156		Planned	
Project FA		1157		Completed	
Project FB		1158		In Progress	
Project FC		1159		On Hold	
Project FD		1160		Planned	
Project FE		1161		Completed	
Project FF		1162		In Progress	
Project FG		1163		On Hold	
Project FH		1164		Planned	
Project FI		1165		Completed	
Project FJ		1166		In Progress	
Project FK		1167		On Hold	
Project FL		1168		Planned	
Project FM		1169		Completed	
Project FN		1170		In Progress	
Project FO		1171		On Hold	
Project FP		1172		Planned	
Project FQ		1173		Completed	
Project FR		1174		In Progress	
Project FS		1175		On Hold	
Project FT		1176		Planned	
Project FU		1177		Completed	
Project FV		1178		In Progress	
Project FW		1179		On Hold	
Project FX		1180		Planned	
Project FY		1181		Completed	
Project FZ		1182		In Progress	
Project GA		1183		On Hold	
Project GB		1184		Planned	
Project GC		1185		Completed	
Project GD		1186		In Progress	
Project GE		1187		On Hold	
Project GF		1188		Planned	
Project GG		1189		Completed	
Project GH		1190		In Progress	
Project GI		1191		On Hold	
Project GJ		1192		Planned	
Project GK		1193		Completed	
Project GL		1194		In Progress	
Project GM		1195		On Hold	
Project GN		1196		Planned	
Project GO		1197		Completed	
Project GP		1198		In Progress	
Project GQ		1199		On Hold	
Project GR		1200		Planned	
Project GS		1201		Completed	
Project GT		1202		In Progress	
Project GU		1203		On Hold	
Project GV		1204		Planned	
Project GW		1205		Completed	
Project GX		1206		In Progress	
Project GY		1207		On Hold	
Project GZ		1208		Planned	
Project HA		1209		Completed	
Project HB		1210		In Progress	
Project HC		1211		On Hold	
Project HD		1212		Planned	
Project HE		1213		Completed	
Project HF		1214		In Progress	
Project HG		1215		On Hold	
Project HH		1216		Planned	
Project HI		1217		Completed	
Project HJ		1218		In Progress	
Project HK		1219		On Hold	
Project HL		1220		Planned	
Project HM		1221		Completed	
Project HN		1222		In Progress	
Project HO		1223		On Hold	
Project HP		1224		Planned	
Project HQ		1225		Completed	
Project HR		1226		In Progress	
Project HS		1227		On Hold	
Project HT		1228		Planned	
Project HU		1229		Completed	
Project HV		1230		In Progress	
Project HW		1231		On Hold	
Project HX		1232		Planned	
Project HY		1233		Completed	
Project HZ		1234		In Progress	
Project IA		1235		On Hold	
Project IB		1236		Planned	
Project IC		1237		Completed	
Project ID		1238		In Progress	
Project IE		1239		On Hold	
Project IF		1240		Planned	
Project IG		1241		Completed	
Project IH		1242		In Progress	
Project II		1243		On Hold	
Project IJ		1244		Planned	
Project IK		1245		Completed	
Project IL		1246		In Progress	
Project IM		1247		On Hold	
Project IN		1248		Planned	
Project IO		1249		Completed	
Project IP		1250		In Progress	
Project IQ		1251		On Hold	
Project IR		1252		Planned	
Project IS		1253		Completed	
Project IT		1254		In Progress	
Project IU		1255		On Hold	
Project IV		1256		Planned	
Project IW		1257		Completed	
Project IX		1258		In Progress	
Project IY		1259		On Hold	
Project IZ		1260		Planned	
Project JA		1261		Completed	
Project JB		1262		In Progress	
Project JC		1263		On Hold	
Project JD		1264		Planned	
Project JE		1265		Completed	
Project JF		1266		In Progress	
Project JG		1267		On Hold	
Project JH		1268		Planned	
Project JI		1269		Completed	
Project JJ		1270		In Progress	
Project JK		1271		On Hold	
Project JL		1272		Planned	
Project JM		1273		Completed	
Project JN		1274		In Progress	
Project JO		1275		On Hold	
Project JP		1276		Planned	
Project JQ		1277		Completed	
Project JR		1278		In Progress	
Project JS		1279		On Hold	
Project JT		1280		Planned	
Project JU		1281		Completed	
Project JV		1282		In Progress	
Project JW		1283		On Hold	
Project JX		1284		Planned	
Project JY		1285		Completed	
Project JZ		1286		In Progress	
Project KA		1287		On Hold	
Project KB		1288		Planned	
Project KC		1289		Completed	
Project KD		1290		In Progress	
Project KE		1291		On Hold	
Project KF		1292		Planned	
Project KG		1293		Completed	
Project KH		1294		In Progress	
Project KI		1295		On Hold	
Project KJ		1296		Planned	
Project KK		1297		Completed	
Project KL		1298		In Progress	
Project KM		1299		On Hold	
Project KN		1300		Planned	
Project KO		1301		Completed	
Project KP		1302		In Progress	
Project KQ		1303		On Hold	
Project KR		1304		Planned	
Project KS		1305		Completed	
Project KT		1306		In Progress	
Project KU		1307		On Hold	
Project KV		1308		Planned	
Project KW		1309		Completed	
Project KX		1310		In Progress	
Project KY		1311		On Hold	
Project KZ		1312		Planned	
Project LA		1313		Completed	
Project LB		1314		In Progress	
Project LC		1315		On Hold	
Project LD		1316		Planned	
Project LE		1317		Completed	
Project LF		1318		In Progress	
Project LG		1319		On Hold	
Project LH		1320		Planned	
Project LI		1321		Completed	
Project LJ		1322		In Progress	
Project LK		1323		On Hold	
Project LL		1324		Planned	
Project LM		1325		Completed	
Project LN		1326		In Progress	
Project LO		1327		On Hold	
Project LP		1328		Planned	
Project LQ		1329		Completed	
Project LR		1330		In Progress	
Project LS		1331		On Hold	
Project LT		1332		Planned	
Project LU		1333		Completed	
Project LV		1334		In Progress	
Project LW		1335		On Hold	
Project LX		1336		Planned	
Project LY		1337		Completed	
Project LZ		1338		In Progress	
Project MA		1339		On Hold	
Project MB		1340		Planned	
Project MC		1341		Completed	
Project MD		1342		In Progress	
Project ME		1343		On Hold	
Project MF		1344		Planned	
Project MG					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2d Film G391 7/28/67 kk

09886

CERTIFICATE OF DEATH

09892

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>67-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>100 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sewell</u>				d. STREET ADDRESS <u>Box 424</u> <u>Box 442, Route 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Donna</u> Middle <u>Anne</u> Last <u>Thomsen</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 January 1947</u>	9. AGE (In years last birthday) <u>20 yrs.</u>	IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>		IF UNDER 24 HRS. Hours <u>20</u> Min. <u>20</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk typist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Kenneth Thomsen</u>				14. MOTHER'S MAIDEN NAME <u>Grace Duval</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>005-48-5028</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> <u>20H1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding Diathesis--Severe</u> DUE TO (c) <u>Chronic Myelogenous Leukemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Hrs.</u> <u>2 Wks.</u> <u>1 10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>20</u> (this hospital) attended the deceased from <u>10 April</u> , 1967, to <u>19 July</u> , 1967, that <u>20</u> (we) last saw the deceased alive on <u>19 July</u> , 1967, and that death occurred at <u>12:25M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Charles M. Haskell</u>				22b. DATE SIGNED <u>19 July 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles M. Haskell, M.D.</u>	
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>		22e. MED. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-22-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony's Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Jackman, Maine</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>JUL 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MINISTRY OF DEFENSE

SECRET

FOR THE USE OF

SECRET

TO THE SECRETARY OF DEFENSE

FROM THE SECRETARY OF DEFENSE

DATE: 10/1/50

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

098893

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY in 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>			d. STREET ADDRESS <b>7518 Cornith Drive</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>THOMSON</b> Last				4. DATE OF DEATH Month <b>7</b> Day <b>7</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 March 1926</b>		9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Boston, Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Thomson</b>				14. MOTHER'S MAIDEN NAME <b>Florence Bigelow</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>5-30-65</b>		17. INFORMANT <b>Alexandria</b> Address <b>Virginia</b> <b>Mrs. Mary I. Thomson, 7518 Cornith Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1992 Cardio Respiratory Failure</b> DUE TO (b) <b>Diffuse Metastatic Sarcoma</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>6 July</b> , 19 <b>67</b> , to <b>7 July</b> , 19 <b>67</b> , that (X) (we) lost saw the deceased alive on <b>July 7</b> , 19 <b>67</b> , and that death occurred at <b>4:15 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>Robert A. McGuire</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8 July 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>J.B. EMERY</b>				22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/12/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>		
24. FUNERAL DIRECTOR <b>McGuire's Funeral</b> ADDRESS <b>Home, 1820 9th Street, N.W., Washington D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 12 1967</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

sin-ryi?

• **Stress**

Tab. 1

1998 Count: 1214

(1077) 0529496

2000

5

95

7501 2 0

20-06-3-

100

安山

508 7505 8

NAVY HOSPITAL, FORT MONROE, VIRGINIA

[illegible]

INTERVIEW

NAME: \_\_\_\_\_

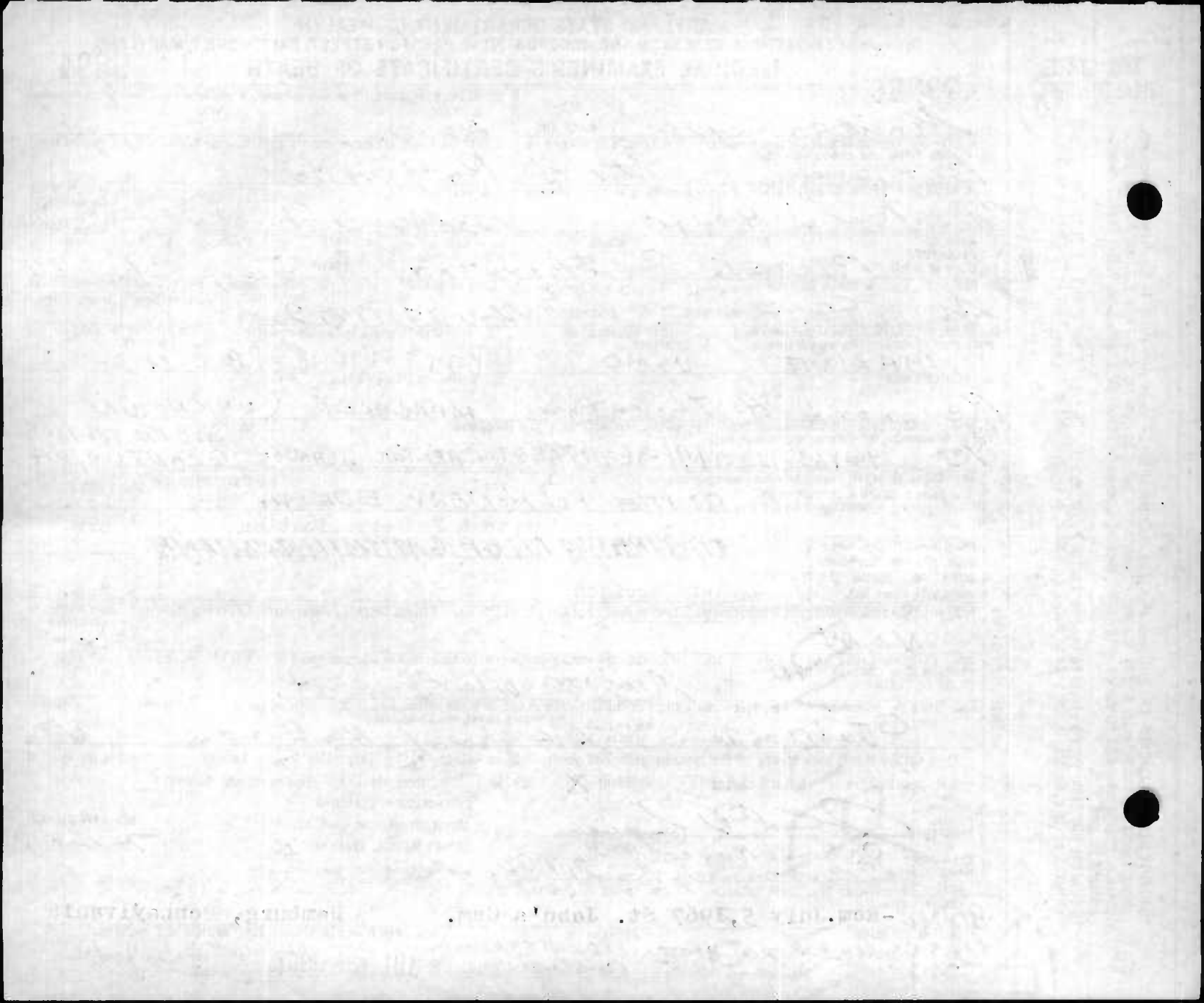


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

<div>Items 18&amp;20a Film 391 8-11-67 ams</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>09894</div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Penn</u> b. COUNTY <u>Pottsville</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pottsville</u>					c. LENGTH OF STAY IN 1b <u>4 hrs</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hosp</u>					d. STREET ADDRESS <u>423 Marsh Creek St</u>						
3. NAME OF DECEASED (Type or print) <u>Richard E Thornton</u> First Middle Last					4. DATE OF DEATH <u>July 1 1967</u> Month Day Year						
SEX <u>M</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 17 1945</u> Yrs. Months Days		9. AGE (In years, last birthday) <u>21</u> yrs. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MARINE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>USMC</u>		11. BIRTHPLACE (State or foreign country) <u>POTTSVILLE PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Raymond H. Thornton</u>					14. MOTHER'S MAIDEN NAME <u>MARGARET (UNKNOWN)</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>9 MAY 63 - 1 JUL 67</u>					16. SOCIAL SECURITY NO. <u>91-36-3799</u>					17. INFORMANT <u>SGT CARLTON JOHNSON</u> Address <u>H+S BN TBS MCS QUANTICO, VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>ACUTE PULMONARY EDEMA &amp; hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> DUE TO <u>Pulmonary contusion &amp; Fat embolization</u> <u>4 hrs.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>ASPIRATION IN 110 FIBROBLASTIC INFLAMMATION</u> DUE TO (c) <u>Auto accident</u> <u>4 hrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Auto mobile Accident</u>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year <u>July 1 1967</u> Hour <u>8:00</u> a.m. p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway near Quantico</u>		20f. (City or town) (County) (State) <u>VA</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John H. Rogers</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>John H. Rogers MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
ADDRESS (Street, city, town, or county) <u>1919 Jamnivaly Rd, P.O. Box 157, Pottsville, PA</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL - Rem.</u>					23b. DATE THEREOF <u>July 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Hamburg, Pennsylvania</u>		
24. FUNERAL DIRECTOR <u>FALLS CHURCH FUNERAL HOME</u> ADDRESS <u>1102 WEST BRADST.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
DATE <u>JUL 5 1967</u>											



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Other along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09883

09885

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. LENGTH OF STAY IN 1b <i>D. O. A.</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash. San + Hospital</i>			d. STREET ADDRESS <i>503 New York Ave</i>		
3. NAME OF DECEASED (Type or print) <i>Ralph Porter Tittsler</i>			4. DATE OF DEATH Month <i>7</i> Day <i>9</i> Year <i>1967</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-10-99</i>		9. AGE (In years last birthday) <i>68</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bacteriologist Dept of Agric</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Laurence Co. Penn</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Warren C. Tittsler</i>			14. MOTHER'S MAIDEN NAME <i>Grace Porter</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-44-0482</i>	17. INFORMANT <i>503 New York Ave. Address: Takoma Park, Md.</i> <i>wife - Mrs. L. Tittsler</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> <i>Acute Coronary Insufficiency</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <i>30</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>July 9, 1967</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Trans-burial</i>		23b. DATE THEREOF <i>July 13, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Neshannock Cemetery</i>	
24. FUNERAL DIRECTOR <i>Glen Carter Warner E. Humphrey, Inc.</i>		23d. LOCATION (City or Town) (County) (State) <i>New Wilmington, Penna.</i>		25a. REC'D BY REGISTRAR DATE <i>JUL 13 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>					



6 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09880

09886

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WASHINGTON D.C.</b> COUNTY <b>N. W.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARIUM HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WARNER</b> Last <b>TORBERT</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>5<sup>th</sup></b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-29-89</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED GOV. EMPLOYEE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>	
13. FATHER'S NAME <b>FRANCIS TORBERT</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE DALRYMPLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WWI</b>		16. SOCIAL SECURITY NO. <b>578-32-8885</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC SEVERE CONGEST. HEART FAILURE</b> DUE TO (c) <b>CORONARY ARTERY DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>URSEMIA ANEMIA</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-16</b> , 19 <b>67</b> , to <b>7-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-5</b> , 19 <b>67</b> , and that death occurred at <b>430AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>John L. Ford</b>		22b. DATE SIGNED <b>7-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN L. FORD MD</b>		22d. ADDRESS <b>831 UNIVERSITY BLVD SILVER SPRING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>7/8/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>		25. REC'D BY REGISTRAR <b>St. W. JUL 10 1967</b>	
ADDRESS <b>Washington, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09891

CERTIFICATE OF DEATH

09897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Dist. of Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 mths.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Tourkin</u> Middle <u>Tourkin</u> Last		4. DATE OF DEATH Month <u>JULY</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/14/11</u> 9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Regional director Jewish Beth Fund</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alter Tourkin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes. World War II</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Popish</u>	
16. SOCIAL SECURITY NO. <u>15740</u>		17. INFORMANT <u>Miriam Tourkin</u> Address <u>Suburban</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Pancreas</u> 157X <u>2 wide spread metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to</u> (c) <u>due to</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 1966</u> to <u>July 1967</u> , that (I) (we) last saw the deceased alive on <u>July 11 1967</u> and that death occurred at <u>4:32 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Nancy Braden</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 17, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ADAMS ISRAEL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, DC</u>
24. FUNERAL DIRECTOR <u>CONDORCE FUNERAL HOME</u> ADDRESS <u>4217 9TH ST. N.W.</u>		25a. REC'D BY REGISTRAR <u>JUL 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF TEXAS

1901

1901

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

*[Faint, illegible text at the bottom of the page]*

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>12014 Livingston St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GIOVANNIA</b> Middle <b>Aiello</b> Last <b>Trapani</b>				4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 67</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/23/92</b>	9. AGE (In years last birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Palermo, Sicily</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Cesare <del>XXXXXXXXX Aiello</del> TRAPANI</b>				14. MOTHER'S MAIDEN NAME <b>Giovanna Guiseppa AIELLO</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter, Wheaton, Maryland</b> <b>Julia Rosenthal 12014 Livingston St</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary Insufficiency</b> DUE TO (b) <b>Arteriosclerotic Heart Disease.</b> DUE TO (c) <b>Whn!.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Read</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>7-21-1967</b>	
EXAMINER'S NAME (Type) <b>BELODEN R. READ M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 29, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas 8434 Georgia Avenue</b> <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>				25a. REC'D BY REGISTRAR <b>AUG 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09893

09899

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>		c. LENGTH OF STAY in 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allentown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>3926 Byrd Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mark Joseph WALLACE</b>				4. DATE OF DEATH Month <b>7</b> Day <b>26</b> Year <b>19 67</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1944</b>		9. AGE (In years last birthday) <b>23</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Military</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>		11. BIRTHPLACE (State or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Sylvester Wallace Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alice Donahue</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 7-28-66 to 7-26-67</b>				16. SOCIAL SECURITY NO <b>173361224</b>			
17. INFORMANT <b>Service Record</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Head Injuries Multiple Severe - 825.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Trauma from Auto Accident.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car involved in auto accident</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>2:30</b> <b>July 22 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>New Frederickburg Va.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John G. Ball</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>7/28/67</b>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>31 July 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington, National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Fall Church Funeral Home</b>		25a. REC'D BY REGISTRAR <b>David S. Sanders</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 2 1967</b>	

Paul Cannon Funeral Home  
1102 W. 1st St.  
Atlin, Va.

John G. Hill

Yes 7-25-50 to 7-26-50  
George Sylvester Wallace Jr.  
1730134  
Service Record  
Mary Alice Donahue  
Brooklyn, New York  
May 15, 1944  
WALLACE  
Joseph  
3886 Byrd Ave  
Atlin, Va.  
Pennsylvania

Military

Male

Mark

Naval Hospital

Belmonte Naval

Montgomery



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09894

09900

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		d. STREET ADDRESS <u>9200 Sudbury Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Cooke Walker</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-87</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>80</u> Days <u>14</u> Hours <u>19</u> Min. <u>67</u>	11. IF UNDER 24 HRS. Months <u>80</u> Days <u>14</u> Hours <u>19</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Mont. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Crittenden H. Walker</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Coombs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-14-4487</u>	
17. INFORMANT <u>Mrs. W. Cooke Walker Same as 2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>July 14, 1967</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-17-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		23d. LOCATION (City or Town) (County) (State) <u>Laytonsville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	
ADDRESS <u>Laytonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1

Retired Farmer  
Christopher H. Walker

Male

Mont. Co., Md.

USA

Virginia Commo

278-11-1107 Mrs. W. Cooke Walker Sr. as S

Female 7-17-07  
Laytonville, Md.  
Laytonville, Md.  
Mont. Co., Md.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09901

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home for the Aged, Inc.</b>		d. STREET ADDRESS <b>Chipper Hill, Rt. 1</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Nelson</b> Last <b>Wareheim</b>		4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1872</b>
9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>steel foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel plant</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Maple Grove, Carroll County Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Wareheim</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Bolinger</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>216-10-4089 A</b>		17. INFORMANT <b>Asbury Methodist Home, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO (b) <b>GENERAL ARTERIO SCLEROSIS AND</b> DUE TO (c) <b>ARTERIO SCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>URINARY TRACT INFECTION &amp; B.P.H.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 8, 1967</b> , to <b>JULY 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>JULY 14, 1967</b> , and that death occurred at <b>10:45 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert C. Daddario</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/14/67</b>
22c. PHYSICIAN'S NAME (Type) <b>ROBERT C. DADDARIO</b>		22d. ADDRESS <b>3413 CEDAR LANE BETHESDA</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>	23b. DATE THEREOF <b>7-17-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Levinson Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Bethesda Md.</b>
24. FUNERAL DIRECTOR <b>Loring Byers</b>		25a. REC'D BY REGISTRAR <b>JUL 17 1967</b>	
ADDRESS <b>5728 Liberty Road</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK

County of ...

City of ...

... ..

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09896

CERTIFICATE OF DEATH

09902

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
c. LENGTH OF STAY in 1b <i>16 days</i>		d. STREET ADDRESS <i>7229 Minter Place</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clara Agnes Warner</i>		4. DATE OF DEATH Month Day Year <i>7 9 1967</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-12-1877</i>
9. AGE (In years last birthday) <i>90 yrs.</i>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Pope</i>		14. MOTHER'S MAIDEN NAME <i>Not available</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>578-30-8580</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> <i>4200</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of the cervix</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE NOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>March, 1967</i> to <i>July 7, 1967</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>July 7, 1967</i> , and that death occurred at <i>8:35 A.M.</i> from causes and on the date stated above.			
22a. SIGNATURE <i>Morton Altschuler</i>		22b. DATE SIGNED <i>7-9-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Morton Altschuler, M.D.</i>		22d. ADDRESS <i>9205 New Hampshire Ave. N.W.</i>	
23a. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>July 12, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cemetery</i>	23d. LOCATION (City or town) (County) (State) <i>Washington D.C.</i>
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll St. N.W. Wash. D.C.</i>		25. RECEIVED BY REGISTRAR <i>JUL 11 1967</i>	
26. REGISTRAR'S SIGNATURE <i>James J. Jones</i>			

STATE OF TEXAS

County of \_\_\_\_\_

City of \_\_\_\_\_

State of \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09903

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dover Rd.</u>				d. STREET ADDRESS <u>Dover Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Washington</u> Last <u>Washington</u>				4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23 1904</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ad. Washington</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Fletcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia -</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease -</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John B. Ball</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>7/9/67</u>	
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LINCOLN PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCKVILLE, MONTG. MD.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>ROCKVILLE, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUL 14 1967</u>							

ROCKVILLE, MARYLAND JUL 14 1961  
JAMES J. HARRIS  
JAMES J. HARRIS  
JAMES J. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09898

CERTIFICATE OF DEATH

09904

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN TB <b>34 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> <b>154</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				d. STREET ADDRESS <b>1112 Grandin Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH G. WATKINS</b> First Middle Last				4. DATE OF DEATH <b>July 7, 1967</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1901</b>	
				9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Evan Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Bradley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>200-14-2661</b>		17. INFORMANT <b>Bessie Schark-Rockville, Md.</b> Address <b>1112 Grandin Ave.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2041 cerebral infarction</b> DUE TO (b) <b>hemodynamic shock</b> DUE TO (c) <b>leukemia (acute myeloid)</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>24 hrs</b> <b>6 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/1/67</b> , 19 <b>67</b> , to <b>7/7/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7/7/67</b> , 19 <b>67</b> , and that death occurred at <b>1:30 PM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Stephen N. Jones</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>				22d. ADDRESS <b>Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/11/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Washington</b>		23d. LOCATION (City or Town) (County) (State) <b>Perryopolis. Penn.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL 11 1967</b> DATE		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

Montgomery

Montgomery

Montgomery

Rockville

Rockville

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

1111 1/2 Main Ave.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN TB <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Frederick</b> Last <b>Wessel</b>		4. DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/15/95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Fulton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Wessel</b>		14. MOTHER'S MAIDEN NAME <b>Emma Dinkleman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-368851</b>	
17. INFORMANT <b>Neice, Marie Dasher</b>		Address <b>Oakland Mills Rd. Ellicott City, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Acute Coronary Insufficiency</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>July 31, 1967</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/3/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Lutheran</b>		23d. LOCATION (City or Town) (County) (State) <b>Fulton Maryland</b>	
24. FUNERAL DIRECTOR <b>Donald Ray</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09900

09905

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>19 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9520 Seminole Street</u>				d. STREET ADDRESS <u>9520 Seminole Street</u>			
3. NAME OF DECEASED (Type or print) <u>Bertha</u> <u>E. Elizabeth</u> <u>West</u>				4. DATE OF DEATH Month <u>July</u> Day <u>2nd</u> Year <u>19 67</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1886</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown Burgess</u>				14. MOTHER'S MAIDEN NAME <u>Harriet S. Moore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-5906-B</u>		17. INFORMANT <u>John E. West</u> <u>9520 Seminole St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast with Metastasis</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>	Month, Day, Year <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u>	(County) <u>  </u>	(State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>19 48</u> to <u>2 July 19 67</u> , that (I) (we) last saw the deceased alive on <u>2 July 19 67</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel Dove</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL DOVE, M.D.</u>				22d. ADDRESS <u>1801 Eye St, N.W. #407. Washington D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 5, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09901

09906

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY in 1b <u>9 days</u>		d. STREET ADDRESS <u>#6 Rollins Hall Ct.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Garrett West</u>		4. DATE OF DEATH Month Day Year <u>July 24 1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/89</u>
9. AGE (In years last birthday) <u>77</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Garrett</u>		14. MOTHER'S MAIDEN NAME <u>Roberta Thrift</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-50-7290</u>	
17. INFORMANT <u>Marian W. Walker</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X</u> DUE TO <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>465X</u> (b) <u>PULMONARY INFARCTION, MASSIVE</u> DUE TO <u>465X</u> (c) <u>THROMBO-EMBOLIZATION</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u> <u>10 DAYS</u> <u>10 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 4</u> , 1967, to <u>JULY 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>JULY 24</u> , 1967, and that death occurred at <u>4:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Angle</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>July 24, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		22d. ADDRESS <u>5009 Del Ray Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown</u>	23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>1331 Rock. Pike</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>
		DATE <u>JUL 27 1967</u>	

22001

DEPARTMENT OF HEALTH

STATE OF NEW YORK  
IN SENATE  
January 1, 1914  
REPORT  
OF THE  
COMMISSIONER OF HEALTH  
FOR THE YEAR 1913

1913-1914

THE COMMISSIONER OF HEALTH  
HAS THE HONOR TO SUBMIT  
TO THE SENATE  
THE FOLLOWING REPORT  
FOR THE YEAR 1913  
IN OBEEDIENCE TO  
A RESOLUTION PASSED  
BY THE SENATE  
JANUARY 1, 1914

ALBANY, N. Y.:  
JANUARY 1, 1914.  
PUBLISHED BY THE  
STATE OF NEW YORK  
PRINTED BY THE  
UNIVERSITY OF THE STATE OF NEW YORK  
AT ALBANY

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

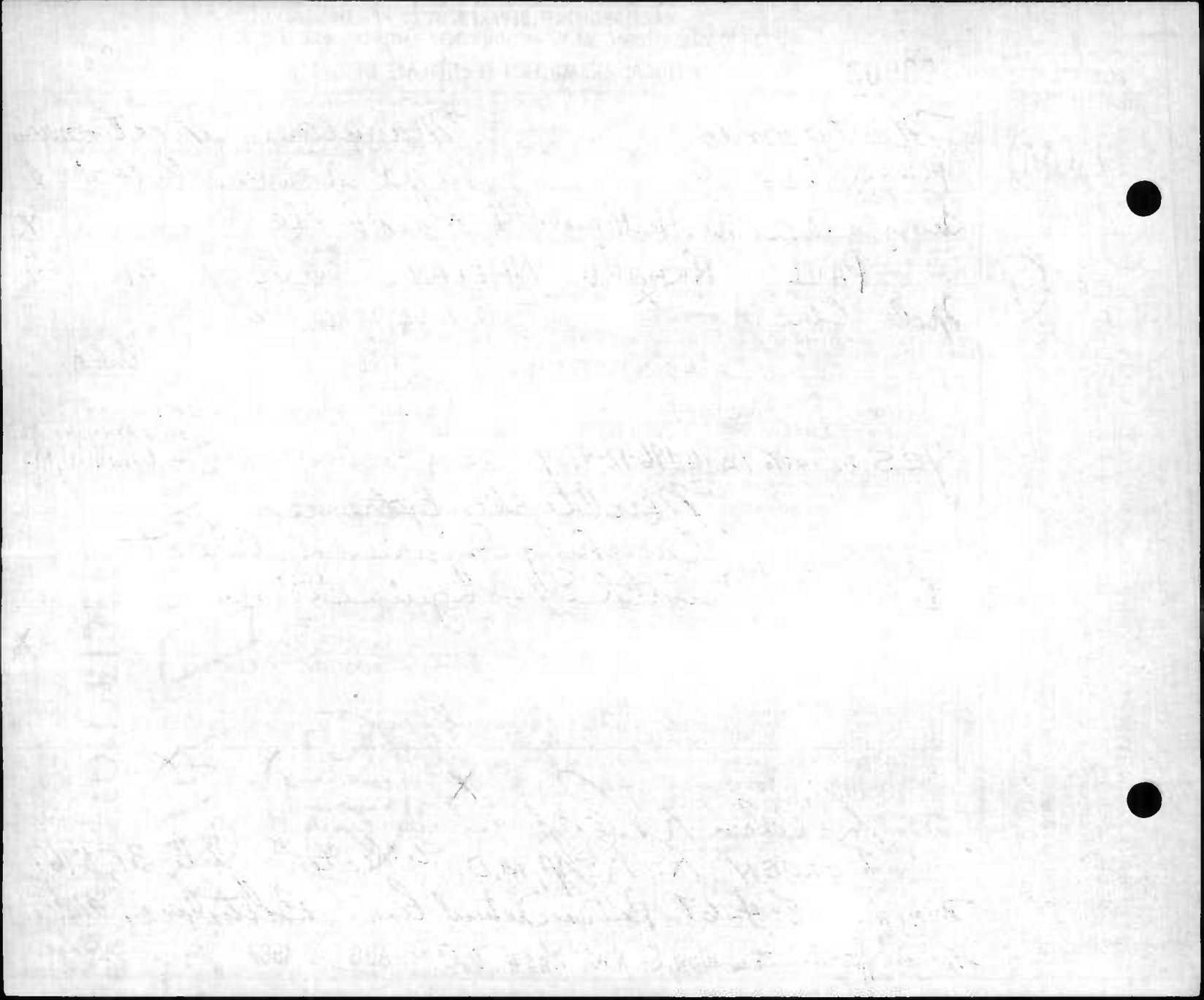
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09902

09907

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Georgia Ave. nr. Heathfield Rd. Rockville</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12712 Danvers Court</u> d. STREET ADDRESS <u>15.1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PAUL RICHARD WHELAN</u> First Middle Last 4. DATE OF DEATH <u>JULY 31 1967</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cauc.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 26, 1926</u> 9. AGE (In years last birthday) yrs. <u>40</u> 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James P. Whelan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hazel Denis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 2-22-45 to 7-23-46</u>		16. SOCIAL SECURITY NO. <u>196-12-4939</u>	
17. INFORMANT <u>Mary Regina Whelan - OXON HILL, MD</u>		Address <u>5004 KENMONT RD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple, Extreme</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Crushing Injuries of Chest</u> (c) <u>with Exsanguination.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>July 31, 1967</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, County) <u>Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-4-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis J. Collins 3821-14TH ST. N.W. WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 4 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			





CERTIFICATE OF DEATH

09903

09908

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>15.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SHIRAZ 4609 Flower Valley Drive</b>		d. STREET ADDRESS <b>4609 Flower Valley Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARRIE C. WHITE</b>		4. DATE OF DEATH Month Day Year <b>July 14 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/30/84</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>2 14</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James H. Corkan</b>		14. MOTHER'S MAIDEN NAME <b>Whipple</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>205-24-7033</b>	
17. INFORMANT Address <b>Vallie Anne Halpine- Niece- same item 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive + arteriosclerotic HD</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>cerebral arteriosclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 28, 1967</b> to <b>July 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>June 14, 1967</b> , and that death occurred at <b>12:27</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert Hunter, Jr.</b> M.D.		22b. DATE SIGNED <b>7/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>		22d. ADDRESS <b>50 West Edmonston, Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>	23b. DATE THEREOF <b>7/17/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Allegheny Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Pittsburg, Pa.</b>
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Pike JUL 17 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

1900

NAME	JOHN A. JONES
AGE	35
SEX	Male
DATE OF BIRTH	1865
PLACE OF BIRTH	England
EDUCATION	Common School
RELIGION	Methodist
OCCUPATION	Farmer
RESIDENCE	1000 North Main Street, Dallas, Texas
DATE OF DEATH	1900
PLACE OF DEATH	Dallas, Texas
CAUSE OF DEATH	Heart Disease
TESTED BY	Dr. J. H. Smith
CERTIFICATE	Given

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

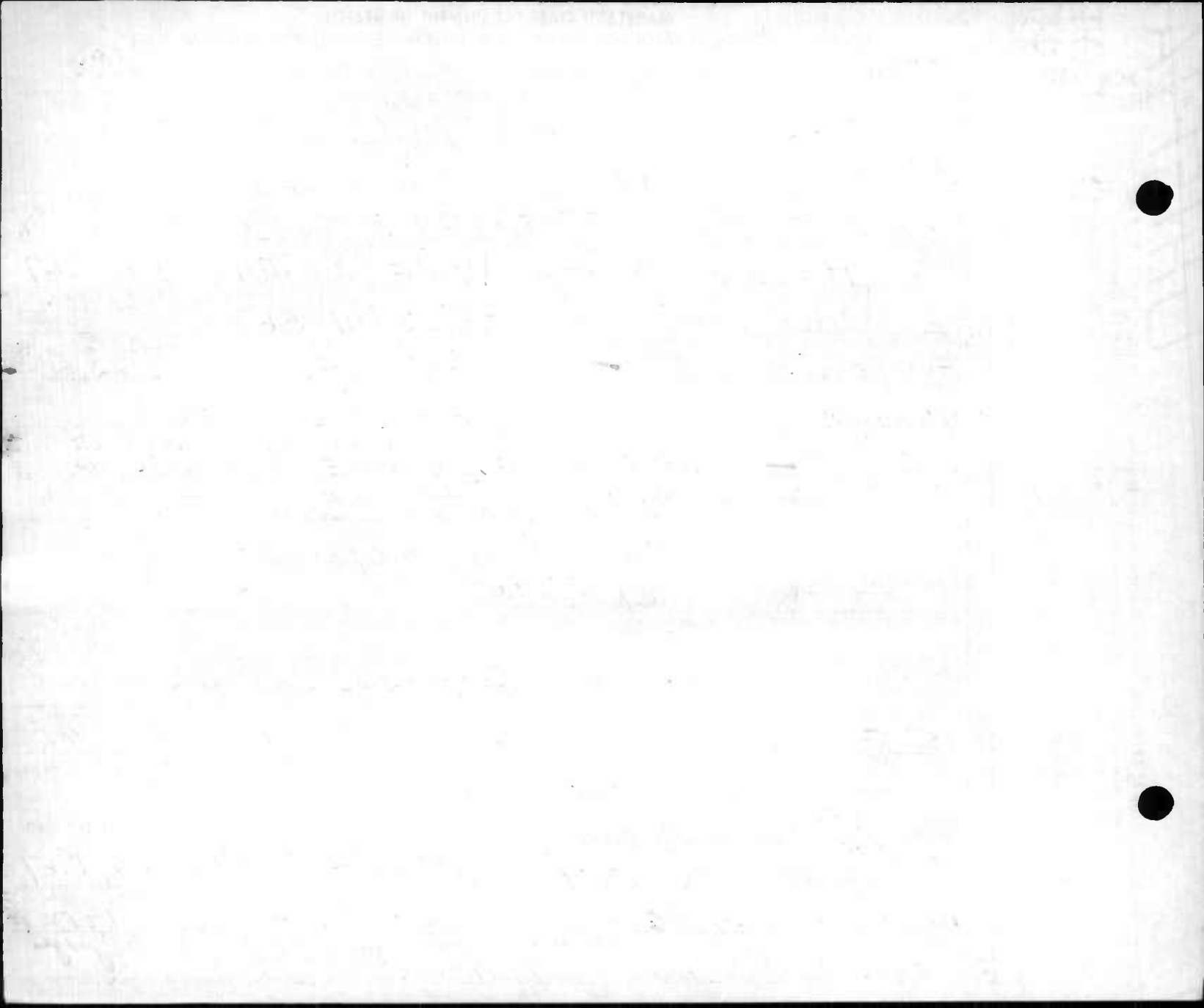
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09904

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09909

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>11 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12213 Fuller Street</u>				d. STREET ADDRESS <u>12213 Fuller St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN RUTH WICE</u>				4. DATE OF DEATH Month Day Year <u>JULY 22 1967</u>			
5. SEX <u>FE</u>	6. COLOR OR RACE <u>CAUC</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1911</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>PAULINE ROOF</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>186-03-9488</u>		17. INFORMANT (SON) - <u>209 Franklin St. PAUL B. WICE, ALEXANDRIA, VA.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to</u> DUE TO <u>hanging, apparently self</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>inflicted.</u> (c) <u>inflicted.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Deceased, depressed, hanged self in basement of home.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Deceased, depressed, hanged self in basement of home.</u>					
20c. TIME OF INJURY Month, Day, Year <u>13:00 p.m. 7-22-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>		EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>JULY 22, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/24/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEMETERY HATTSVILLE. MD.</u>		23d. LOCATION (City or Town) (County) (State) <u>MD.</u>	
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u>		ADDRESS <u>4217-9th</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09905

09910

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. F. W.</u> c. LENGTH OF STAY IN lb <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brook Grove Foundation (Sharon)</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1233 Buysse Cherry Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Benedict A. Widmer</u>		<b>4. DATE OF DEATH</b> Month <u>July</u> Day <u>22</u> Year <u>1967</u>		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12-25-93</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years, last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plate Printer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gov. Printing</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Philadelphia, Penn.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Benedict A. Widmer</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Adiline Kronner</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> <u>Benedict Widmer Jr.</u> Address <u>Cottage City, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (b) <u>PULMONARY CONGESTION</u> (a), stating the underlying cause last. (c) <u>CARCINOMA LUNG.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>OLD STROKE: HEMIPLEGIA; ASCVD: HCD</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that</b> (1) (this hospital) attended the deceased from <u>August 1964</u> to <u>7/22/67</u> , that (1) (we) last saw the deceased alive on <u>7-21-1967</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Donald R. Lewis</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>DONALD R. LEWIS</u>				<b>22b. DATE SIGNED</b> <u>7/23/67</u> <b>22d. ADDRESS</b> <u>OLNEY, MARYLAND</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>7-26-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Laytonsville</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JUL 26 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Gov. Printing

Benjamin A. Warner

William Warner

Benjamin Warner, Cottage City, Md.

Benjamin A. Warner

7-25-57

Benjamin A. Warner

Benjamin A. Warner, Cottage City, Md.

Benjamin A. Warner

7-25-57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
09906  
09911  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>				c. LENGTH OF STAY IN 1b <u>4 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11611 Regency Drive</u>				d. STREET ADDRESS <u>11611 Regency Drive</u>			
3. NAME OF DECEASED (Type or print) <u>YUKIE WILES</u>				4. DATE OF DEATH <u>July 23 1967</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 30, 1918</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Congressional aide</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Honolulu, Hawaii</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Masaichi Hirakawa</u>				14. MOTHER'S MAIDEN NAME <u>Isuru Hirakawa</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>596-07-3591</u>		17. INFORMANT <u>Ernest E. Wiles</u> Address <u>11611 Regency Drive Potomac, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA WITH DIFFUSE ABDOMINAL METASTASES (BIOPSY PROVEN) - PRIMARY SITE UNKNOWN</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 1962</u> , to <u>JULY 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 23 1967</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas P. Dwyer M.D.</u>				22b. DATE SIGNED <u>JULY 23, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS P. DWYER, M.D.</u>	
22d. ADDRESS <u>2121 PENNSYLVANIA AVE. N.W. WASH. D.C.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>July 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town or county) <u>Prince Georges Co. Md.</u> (State) _____	
24. FUNERAL DIRECTOR <u>John B. Thomas</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>JUL 25 1967</u>			

3000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

W 2

31201

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

10000000

JUL 2 1961

10000000

10000000

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09907

CERTIFICATE OF DEATH

09912

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Raymond Rosco Wilks</u>		4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 March 1917</u>
9. AGE (In years lost birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John W. Wilks</u>		14. MOTHER'S MAIDEN NAME <u>Ola Sloane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>1943 - 45</u>		16. SOCIAL SECURITY NO. <u>257-01-5907</u>	
17. INFORMANT <u>The Medical Record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas Septicemia</u> DUE TO (b) <u>Hodgkins Disease Stage III</u> DUE TO (c) <u></u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>7:10</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 12</u> , 19 <u>67</u> , to <u>July 13</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 13</u> , 19 <u>67</u> , and that death occurred at <u>7:10</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Keyes, Jr.</u>		22b. DATE SIGNED <u>14 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>John W. Keyes, Jr., M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a. BURIAL, CREMATION, <u>Burial</u>	23b. DATE THEREOF <u>7-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Bower Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Polk County Ga.</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1980

CERTIFICATE OF DEATH

STATE OF TEXAS  
COUNTY OF DALLAS  
I, the undersigned, Clerk of the County of Dallas, State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, State of Texas.  
Witness my hand and the seal of said County at Dallas, Texas, this 1st day of January, 1981.  
Clerk of the County of Dallas, State of Texas

Robert A. Freeman, 7552 Woodway, Dallas, Texas 75231  
Bertol, N. 1-17-81, 11th Street, University, North County, Ga.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09908

CERTIFICATE OF DEATH

09913

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>Rt. 1, Rocky Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Troy</u> Last <u>Willis</u>		4. DATE OF DEATH Month <u>07</u> Day <u>15</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Willis</u>		14. MOTHER'S MAIDEN NAME <u>Amanda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Medical Records of Montg. General Hospt.</u>		Address <u>Olney, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Cardiac Decompensation</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>7/15/</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/15/</u> , 19 <u>67</u> , and that death occurred at <u>11:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard A. Yates</u> M.D.		22b. DATE SIGNED <u>7/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Yates</u>		22d. ADDRESS <u>OLNEY, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-18-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonsville Mont. Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2002

STATEMENT OF WORK

THE FOLLOWING STATEMENT OF WORK IS A SUMMARY OF THE WORK TO BE PERFORMED BY THE CONTRACTOR FOR THE PROJECT DESCRIBED IN THE REQUEST FOR PROPOSAL.

1. PROJECT DESCRIPTION: The project is a construction project for a new building. The building will be used for office space and will be located in the city of Nashville, Tennessee. The project is estimated to cost \$1,000,000 and is expected to be completed within 12 months.

2. SCOPE OF WORK: The scope of work includes the design, construction, and installation of the building. The contractor is responsible for obtaining all necessary permits and for coordinating with the city of Nashville. The contractor is also responsible for the safety of the construction site and for the timely completion of the project.

3. DELIVERABLES: The deliverables for this project include the design plans, the construction schedule, and the completed building. The contractor is responsible for providing the city of Nashville with all necessary documentation and for ensuring that the building meets all applicable codes and standards.

4. TIMELINE: The project is expected to be completed within 12 months. The contractor is responsible for providing the city of Nashville with a detailed construction schedule and for updating the schedule as the project progresses.

5. BUDGET: The project is estimated to cost \$1,000,000. The contractor is responsible for providing the city of Nashville with a detailed budget and for ensuring that the project is completed within the budget.

6. RISK MANAGEMENT: The contractor is responsible for identifying and managing the risks associated with the project. This includes the risk of cost overruns, schedule delays, and quality issues. The contractor is also responsible for ensuring that the project is completed in accordance with all applicable laws and regulations.

7. COMMUNICATION: The contractor is responsible for maintaining regular communication with the city of Nashville. This includes providing regular status reports and for responding to any questions or concerns that may arise.

8. SIGNATURES: The project is authorized by the city of Nashville. The contractor is responsible for obtaining the necessary signatures from the city and for providing the city with a copy of the signed statement of work.

Daytonville Home, Md.

Daytonville

7-18-07

Partial

Francis H. Barber, Daytonville, Mo.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09909

CERTIFICATE OF DEATH

09914

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Louisiana</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>30 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakdale</b>		d. STREET ADDRESS <b>107 North 16th Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sylvester</b> Middle <b>WILLIS</b> Last		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 22, 1933</b>
9. AGE (In years last birthday) <b>33</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Oakdale, Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Willis</b>		14. MOTHER'S MAIDEN NAME <b>Ansavelia Buxton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes 1953-1967</b>		16. SOCIAL SECURITY NO. <b>434 46 0491</b>	
17. INFORMANT <b>St., Johnson</b> Address <b>City, Tenn</b> <b>Mrs. Wilma Jean Willis, 206 West Locust</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis, primary undetermined</b> <b>1992</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>June 7</b> , 19 <b>67</b> , to <b>July 7</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>July 7</b> , 19 <b>67</b> , and that death occurred at <b>5:20</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>C. P. KESSLER</b>		22b. DATE SIGNED <b>July 8, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. P. KESSLER, M.D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/10/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakdale, Louisiana</b>	
24. FUNERAL DIRECTOR <b>Falls Church Funeral</b> ADDRESS <b>Home</b> <b>1102 West Broad Street, Falls Church, Va.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

2:00

Louisiana

Montgomery

Carolina

Postoffice (rural)

101 North 10th Street

Naval Hospital

July

WILLIS

Sylvester

33

Oct. 22, 1933

Care

Male

Carolina, Louisiana

U. S. Marine Corps

Annville, Kentucky

Richard Willis

St. Louis, Mo.

City, Tenn

Mrs. Willis, 208 West Fourth

1st St. St. Louis

1933-1934

Yes

Continued on reverse side, primary numbered

2:00

June 7

ST

1933

July 6, 1934

Naval Hospital, Bethesda, Md.

C. P. Kessler, M.D.

Carolina, Louisiana

Carolina, Kentucky

English

1115 Church Street, Tallahassee, Fla.  
1102 West Second Street, Tallahassee, Fla.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO., CO.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Md.</u>				c. LENGTH OF STAY IN 1b <u>2 YRS 4 M</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppatown, Md</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>						d. STREET ADDRESS <u>506 Echak Ct.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>M.</u> Last <u>Wilson</u>						4. DATE OF DEATH Month <u>7</u> Day <u>2</u> Year <u>1967</u>					
5a. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-21-1897</u>		9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. BORING</u>						14. MOTHER'S MAIDEN NAME <u>MARY V. WILHELM</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>220-30-0520</u>		17. INFORMANT <u>Mrs. Anna E. Kennedy</u> Address <u>Westminster RD #6</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>-</u>										INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6 March</u> , 19 <u>65</u> , to <u>2 July</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>30 June</u> , 19 <u>67</u> , and that death occurred at <u>4A</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Hampstead Cemetery Md</u>			
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JUL 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09911

CERTIFICATE OF DEATH

09915

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY in 1b <u>10 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>168</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>7300 Wells Blvd. 20783</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Major</u> Middle <u>Howard</u> Last <u>Wolfrey</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1914</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Printing Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dellie Wolfrey</u>				14. MOTHER'S MAIDEN NAME <u>Anna Haina</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>265 105805</u>		17. INFORMANT <u>Patient's Hosp Record.</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bladder Carcinoma</u> <u>1910</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastases +</u> DUE TO (c) <u>Metabolic Acidosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR.</u> <u>6 MONTHS.</u> <u>Weeks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>July 28</u> , 19 <u>67</u> , that (I) (we) lost <u>saw</u> the deceased alive on <u>July 28</u> , 19 <u>67</u> , and that death occurred at <u>5:20</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Hugo G. Graziani, M.D.</u> <u>for Dr. T. Fogarty</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hugo G. Graziani, M.D.</u>				22d. ADDRESS <u>10100 Georgia Ave, S.S. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 31, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro. Geo. Md.</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

100-443887-100



FOR STATE  
HEALTH DEPT

09912

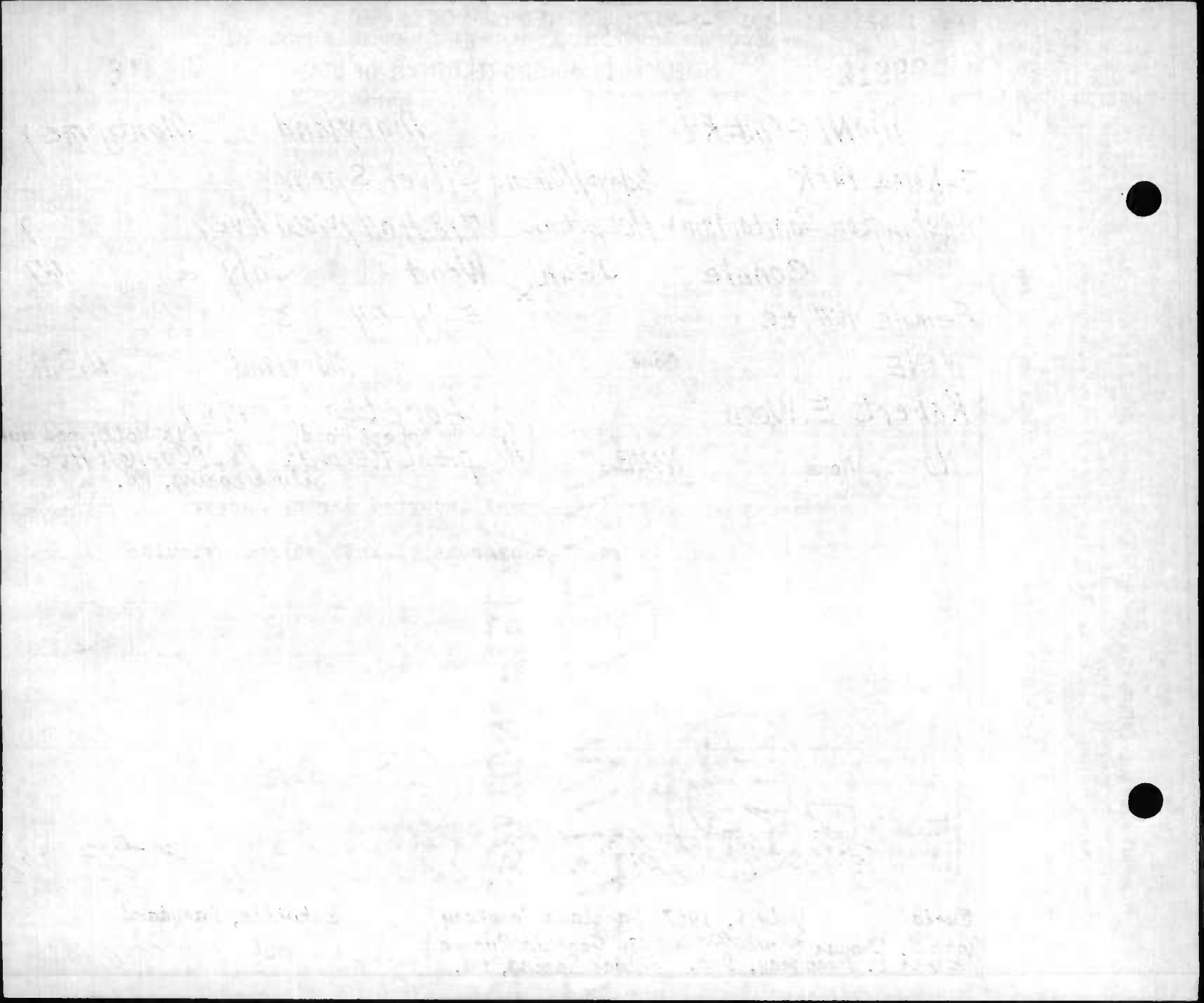
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09916

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 2b <b>3 days/10 hours</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>				d. STREET ADDRESS <b>718 Hollywood Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Connie</b> Middle <b>Jean</b> Last <b>Wood</b>				4. DATE OF DEATH Month <b>July</b> Day <b>2</b> Year <b>1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-14-64</b>	
9. AGE (In years last birthday) <b>3</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during 6 mos. of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during 6 mos. of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert E. Wood</b>				14. MOTHER'S MAIDEN NAME <b>Loretta Farley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Robert Wood</b> Address <b>718 Hollywood Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest incurred during surgery</b> <b>228X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>for cystic hygroma of left supraclavicular fossa</b> DUE TO (c) <b>fossa</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State) <b>Montg.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED <b>July 2, 1967</b>				23. SIGNATURE CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>July 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>				23e. REC'D BY REGISTRAR <b>JUL 10 1967</b>		23f. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas</b> <b>Warner E. Pumphrey, Inc.</b>				24a. ADDRESS <b>8434 Georgia Avenue</b> <b>Silver Spring, Md.</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09913

## CERTIFICATE OF DEATH

09917

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>NEW YORK</b> b. COUNTY <b>TICONDEROGA</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b>		c. LENGTH OF STAY IN 1b <b>10 YRS.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TICONDEROGA</b>		d. STREET ADDRESS <b>8 PARK AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MARYLANDER Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First Middle Last <b>L. WOOD</b>		4. DATE OF DEATH Month Day Year <b>7 7 1967</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-1-1882</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>N. YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Myron Rickert</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Bump</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>RUTH L. WOOD-801 S. WALTER REED DR.</b>		Address <b>ARLINGTON, VA</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>H221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1/66</b> to <b>7/7/67</b> , 19 <b>67</b> that (I) <b>(no)</b> last saw the deceased alive on <b>7/5</b> , 19 <b>67</b> , and that death occurred at <b>11:30pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James P. Kerr</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/8/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>				22d. ADDRESS <b>2661 Ridge Road-Damascus, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>7/9/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valley View Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Ticonderoga, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02913

LOW NO. 8

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

DO

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

XXXXXX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Louisiana</u> b. COUNTY <u>Hammond</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hammond</u>	
c. LENGTH OF STAY IN 1b <u>49</u> days		d. STREET ADDRESS <u>706 North Magnolia Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marilyn Louise Wylie</u>		4. DATE OF DEATH Month Day Year <u>July 1 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 December 1930</u>
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawton C. Mitchell, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Louise Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland 20014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypoglycemia</u> DUE TO (b) <u>Craniopharyngioma</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>this</del> this hospital attended the deceased from <u>May 13 1966</u> to <u>July 1 19 67</u> , that <del>he</del> (we) last saw the deceased alive on <u>July 1 19 67</u> , and that death occurred at <u>12:15M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Duane B. Gainsburg, M.D.</u>		22b. DATE SIGNED <u>2 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Duane B. Gainsburg, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md. 20014</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hammond Louisiana</u>
24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>		25a. RECD BY REGISTRAR <u>JUL 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

[illegible]

\_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09915

## CERTIFICATE OF DEATH

09920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 151	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9309 Harvey Road</b>		d. STREET ADDRESS <b>9309 Harvey Road</b>	
3. NAME OF DECEASED (Type or print) First <b>SULA</b> Middle <b>MARY</b> Last <b>YERMAN</b>		4. DATE OF DEATH Month <b>July</b> Day <b>18th</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 15, 1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) <b>Latvia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elias Shaivitz</b>		14. MOTHER'S MAIDEN NAME <b>Golda Garfield</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hilda Resiman, Daughter</b>		Address <b>same as No. 2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>ATHEROSCLEROTIC HEART DISEASE</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>LESS THAN 1 HR</b> <b>UNKNOWN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 17, 1967</b> , to <b>JULY 18, 1967</b> , that (I) (the) last saw the deceased alive on <b>JULY 18, 1967</b> , and that death occurred at <b>8 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Edward A. Beeman</b> M.D.		22b. DATE SIGNED <b>JULY 18, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD A. BEEMAN</b>		22d. ADDRESS <b>1015 SPRING ST. SILVER SPRING MD 20910</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 19, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Beth Tefilah Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Balto., Md.</b>
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b> ADDRESS <b>4217 9th Street N.W.</b>		25a. REGISTRY REGISTRAR <b>JUL 21 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

DEPARTMENT OF HEALTH

1901

REPORT

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09918

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09921

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12325 New Hamp Ave</b>				c. LENGTH OF STAY IN 1b <b>months</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Colonial Villa Nursing Home</b>				d. STREET ADDRESS <b>8907 24<sup>th</sup> Ave</b>			
3. NAME OF DECEASED (Type or print) First <b>LOARN</b> Middle <b>STANLEY</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>July</b> Day <b>17</b> Year <b>1967</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-21-78</b>	9. AGE (In years last birthday) <b>89</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		13. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>		14. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. FATHER'S NAME <b>Issac Newton young</b>				16. MOTHER'S MAIDEN NAME <b>Ruby Cermintine</b>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>261-10-2978</b>		19. INFORMANT <b>Mary Rock</b> , <b>8907 24<sup>th</sup> Ave (Daughter)</b>			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>56</b> , to <b>7-17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-14</b> , 19 <b>67</b> , and that death occurred at <b>7:25 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>James Whitlock</b>				22b. DATE SIGNED <b>7-17-67</b>		22c. PHYSICIAN'S NAME (Type) <b>JAMES WHITLOCK</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>July 19, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Colman Manor, Prince Georges, Md</b>				24. FUNERAL DIRECTOR <b>J. Arthur Walters</b>		25. REG'D BY REGISTRAR <b>JUL 19 1967</b>	
26. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				27. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

STATE OF CALIFORNIA

IN SENATE,  
January 15, 1907.  
REPORT  
OF THE  
COMMISSIONERS OF THE  
LAND OFFICE,  
FOR THE YEAR  
1906.  
CALIFORNIA: THE STATE PRINTING OFFICE,  
1907.

1  
12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
Items #15 & 17 filed 039107/1967 ph					09922				
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					c. LENGTH OF STAY IN 1b <b>Bethesda</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5106 Manning Drive</b>					d. STREET ADDRESS <b>5106 Manning Drive</b>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>B.</b> Last <b>YOUNG</b>					4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-30-1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Cyrus H. Young</b>					14. MOTHER'S MAIDEN NAME <b>Caroline Knouse</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>577-03-6295</b>		17. INFORMANT <b>T. Gordon Young</b>			Address <b>5106 Manning Dr. Bethesda Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X TERMINAL BRONCHOPNEUMONIA</b> DUE TO (b) <b>THROMBOSIS LEFT MIDDLE CEREBRAL ARTERY</b> DUE TO (c) <b>ARTERIOSCLEROSIS GENERAL AND CEREBRAL</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 MONTHS</b> <b>6 YEARS</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>DEC. 21, 1965</b> to <b>JULY 24, 1967</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>JULY 24, 1967</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Robert G. Angle</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>JULY 24, 1967</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert G. Angle</b>					22d. ADDRESS <b>5009 Del Ray Ave. Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-27-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>					25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>				
25b. REGISTRAR'S SIGNATURE <b>5130 Wisc. Ave. N.W. Wash. DC.</b>					DATE <b>JUL 28 1967</b>				

0001

Montgomery

Montgomery

Barred

Barred

Blue Mountain

Blue Mountain

25

July 24

BA

E-30-1983

X

Blue

Blue

U.S.A.

Barred

Barred

Barred

Barred

Blue Mountain

Blue Mountain

Blue Mountain

Blue Mountain

Blue Mountain

Blue Mountain

Blue Mountain

Blue Mountain

Blue Mountain

JUL 24 1987

JUL 24 1987



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN lb <b>24 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SAN. &amp; HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK 15.1</b>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>NMN</b> Last <b>YOUNGBLOOD</b>		d. STREET ADDRESS <b>7131 MAPLE AVE.</b>	
5. SEX <b>FE</b>		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. COLOR OR RACE <b>Wh</b>		7. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1967</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/28/84</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES McDONALD</b>		14. MOTHER'S MAIDEN NAME <b>KIDWELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac hypertrophy with hypertension and heart failure</b> 443X DUE TO (b) <b>Associated: pulmonary atelectasis, severe with bilateral hydrothorax</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>			
INTERVAL BETWEEN ONSET AND DEATH years days			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1967</b> , to <b>7/21/67</b> , 19 <b>7/21/67</b> , that (I) (we) last saw the deceased alive on <b>7/21/67</b> 19 <b>7/21/67</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>M. B. QUEEN</b>		22b. DATE SIGNED <b>7/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. B. QUEEN</b>		22d. ADDRESS <b>344 Univ. Blvd W Silver Spring</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>July 25-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Smithfield Prince Georges Md.</b>	
24. FUNERAL DIRECTOR <b>Christine Walters, 284 Carroll St NW Wash DC</b>		25a. REC'D BY REGISTRAR <b>JUL 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

2101

2102

2103

2104

2105

2106

2107

2108

2109

2110

2111

2112

2113

2114

2115

2116

2117

2118

2119

2120

2121

2122

2123

2124

2125

2126

2127

2128

2129

2130

2131

2132

2133

2134

2135

2136

2137

2138

2139

2140

2141

2142

2143

2144

2145

2146

2147

2148

2149

2150

2151

2152

2153

2154

2155

2156

2157

2158

2159

2160

2161

2162

2163

2164

2165

2166

2167

2168

2169

2170

2171

2172

2173

2174

2175

2176

2177

2178

2179

2180

2181

2182

2183

2184

2185

2186

2187

2188

2189

2190

2191

2192

2193

2194

2195

2196

2197

2198

2199

2200

2201

2202

2203

2204

2205

2206

2207

2208

2209

2210

2211

2212

2213

2214

2215

2216

2217

2218

2219

2220

2221

2222

2223

2224

2225

2226

2227

2228

2229

2230

2231

2232

2233

2234

2235

2236

2237

2238

2239

2240

2241

2242

2243

2244

2245

2246

2247

2248

2249

2250

2251

2252

2253

2254

2255

2256

2257

2258

2259

2260

2261

2262

2263

2264

2265

2266

2267

2268

2269

2270

2271

2272

2273

2274

2275

2276

2277

2278

2279

2280

2281

2282

2283

2284

2285

2286

2287

2288

2289

2290

2291

2292

2293

2294

2295

2296

2297

2298

2299

2300

2301

2302

2303

2304

2305

2306

2307

2308

2309

2310

2311

2312

2313

2314

2315

2316

2317

2318

2319

2320

2321

2322

2323

2324

2325

2326

2327

2328

2329

2330

2331

2332

2333

2334

2335

2336

2337

2338

2339

2340

2341

2342

2343

2344

2345

2346

2347

2348

2349

2350

2351

2352

2353

2354

2355

2356

2357

2358

2359

2360

2361

2362

2363

2364

2365

2366

2367

2368

2369

2370

2371

2372

2373

2374

2375

2376

2377

2378

2379

2380

2381

2382

2383

2384

2385

2386

2387

2388

2389

2390

2391

2392

2393

2394

2395

2396

2397

2398

2399

2400

2401

2402

2403

2404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09924

09919

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY <b>Berkeley</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>77 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Maryland</b>				d. STREET ADDRESS <b>102 Kent Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Belle</b> Last <b>Zombro</b>				4. DATE OF DEATH Month <b>July</b> Day <b>18</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 November 1923</b>		9. AGE (In years lost birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Owens</b>				14. MOTHER'S MAIDEN NAME <b>Ida Kees</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-34-3473</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas Septicemia</b> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myelogenous Leukemia</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2 years.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>2 May</b> , 1967, to <b>18 July</b> , 1967, that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>18 July</b> , 1967, and that death occurred at <b>4:45</b> PM, from causes and on the date stated above.							
22a. SIGNATURE <b>Michael Emmer</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>19 July 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Michael Emmer, MD.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-22-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Martinsburg - Berkeley W. Va</b>	
24. FUNERAL DIRECTOR <b>H. K. Brown</b> <b>Brown Funeral Home</b>				ADDRESS <b>Martinsburg, W. Va.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 21 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEMORANDUM FOR THE DIRECTOR

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000